### IOM Recommendation

**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.

Excerpt from report: At a time when all federal programs are under close scrutiny and the return on the public’s investment in GME is poorly understood, the committee cannot support maintaining Medicare GME funding at the current level without establishing a path toward realignment of the program’s incentives and a plan for documentation of outcomes. The continuation and appropriate level of funding should be reassessed after the implementation of these reforms.

In a separate section of the report, the IOM states:

The committee considered a range of potential GME funding sources, including maintaining or modifying current Medicare support, an all-payer approach that would require both private and public payers to contribute to GME financing, a dedicated federal GME program independent of the Medicare and Medicaid programs, a significant expansion in Title VII health professions funding directed to physician education, and even the possibility of requiring residents to pay tuition.

It quickly became clear that funding GME through an entitlement program—such as Medicare—provides a level of stability that enables sponsoring institutions to make the commitments to the trainees, faculty, and facilities that GME needs. Advocating for increased federal GME funding would be irresponsible without evidence that the public’s current level of investment is

### Relevant ACP Policy and Staff Analysis

**Relevant ACP policy:**

Payment of Medicare GME funds to hospitals and training programs should be tied to the nation’s health care workforce needs. Payments should be used to meet policy goals to ensure an adequate supply, specialty mix, and site of training.

There should be a substantially greater differential in the weighted formula for determining direct GME payments for residents in primary care fields, including internal medicine. Training programs should receive enough funding to develop the most robust training programs and meet the requirements stipulated by their Residency Review Committees (RRCs).

GME caps should be lifted as needed to permit training of an adequate number of primary care physicians, including general internists, and other specialties facing shortages. Opportunities for GME should exist for both international medical graduates and U.S. medical graduates.

Internal medicine residents should receive exposure to primary care in well-functioning ambulatory settings that are financially supported for their training roles. The Accreditation Council for Graduate Medical Education (ACGME) and RRCs should establish specific goals for increased time spent by residents in ambulatory settings. Mentorship programs should be encouraged. Additional Medicare funding should be provided to facilitate training in all ambulatory settings that provide residency education.

All payers should be required to contribute to a financing pool to support residencies that meet policy goals related to supply, specialty mix, and site of training.

**Staff analysis:** Not consistent with ACP policy. The IOM calls for maintaining the current level of Medicare GME funding, adjusted for inflation for the next ten years.
helping to produce the workforce needed in the 21st century. At the same time, Medicare GME funding should not be reduced from current levels if it can be leveraged for greater public benefit.

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<th>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.</th>
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<tr>
<td>Development and oversight of a strategic plan for Medicare GME financing;</td>
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<td>Research and policy development regarding the sufficiency, geographic distribution, and specialty configuration of the physician workforce;</td>
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<td>Development of future federal policies concerning the distribution and use of Medicare GME funds;</td>
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<td>Convening, coordinating, and promoting collaboration between and among federal agencies and private accreditation and certification organizations; and</td>
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<td>Provision of annual progress reports to Congress and the Executive Branch on the state of GME.</td>
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Excerpt from report: The committee urges Congress and the Secretary of the U.S. Department of Health and

| Relevant ACP policy: |
| A national health care workforce policy is needed to reverse the impending collapse of primary care medicine |

Excerpt from rationale “Currently, the types of residents trained in teaching hospitals are determined by the staffing needs of the particular hospital and the number of funded positions set by the cap in 1996. Medicare GME funds are supposed to help develop the future physician workforce, yet teaching hospitals are not required to consider local, regional, or national workforce needs, perhaps because the nation lacks a national health care workforce policy. The College feels strongly that Medicare GME funds should be tied to the nation’s health care workforce needs. The College is encouraged by the establishment of the National Health Care Workforce Commission, charged with evaluating the nation’s health care workforce needs and providing recommendations to Congress and the Administration on national health workforce priorities, goals, and policies. These policies should include sufficient support to educate and train a supply of health professionals that meets the nation’s health care needs and specifically to ensure an adequate supply and spectrum of primary care physicians trained to manage care for the whole patient.” |

Pilot projects should be introduced to promote innovation in GME and provide training programs with the resources necessary to experiment with innovative training models and incorporate models of care, such as the patient-centered medical home. Congress should consider creating a Center for Medical Education Innovation and Research, parallel to the Center for Medicare and Medicaid Innovation, with dedicated dollars to fund pilots and multisite educational outcomes research and have them more widely accepted if successful.
Comparison of ACP Policy and IOM Report “Graduate Medical Education That Meets the Nation’s Health Needs”

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<th>Human Services to take immediate steps to establish a two-part governance infrastructure for federal GME financing. Transforming Medicare GME financing will require an overarching policy-development and decision-making body and a separate operations center to administer GME payment reforms and solicit and manage demonstrations of new GME payment models. A portion of current GME monies should be allocated to create and sustain these new entities. No additional public funds should be used.</th>
<th>GME financing should be transparent, and accountability is needed to ensure that funds are appropriately designated toward activities related to the educational mission of teaching and training residents.</th>
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<td>GME caps should be lifted as needed to permit training of an adequate number of primary care physicians, including general internists, and other specialties facing shortages. Opportunities for GME should exist for both international medical graduates and U.S. medical graduates. Additional Medicare funding should be provided to facilitate training in all ambulatory settings that provide residency education.</td>
<td>Staff analysis: Not consistent with ACP policy. While the College supports innovation and recognizes the need to improve GME financing, MedPAC’s proposal is “budget neutral”. 10 to 30 percent of Medicare’s $10 billion contribution to GME would go to the transformation fund. Existing Medicare-funded GME positions would continue to receive funding, but at a significantly lower rate since the pool of funds is smaller. The AAMC estimates that it would be a 32 to 35% decrease. This would be disruptive to teaching</td>
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**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.

**Excerpt from report:** 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.

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.

**Excerpt from report:** The fund would be used 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.

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.

Details on allocation to the fund:
The committee suggests that the Operational Fund allocation begin at 90 percent of the total Medicare GME fund, decrease to 70 percent over roughly 3 years and remain at that level for several years, and then return to 90 percent by the 10th year. The Transformation Fund should be allocated the balance of the funds - thus starting at 10 percent of the total, moving up to 30 percent as GME pilots and activities gear up and then returning to the 10 percent allocation as successful pilots and research establish the basis for broad application of GME improvement initiatives, including additional slots.

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 pilots.

Excerpt from report: 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.

Relevant ACP policy:
There should be a substantially greater differential in the weighted formula for determining direct GME payments for residents in primary care fields, including internal medicine. Training programs should receive enough funding to develop the most robust training programs and meet the requirements stipulated by their Residency Review Committees (RRCs).

The federal government should support education and training reform in primary care by:
- Providing funding to encourage medical schools and post graduate residency training programs to improve primary care education and training through grants for mentorship programs, curriculum development for primary care models, and development of materials to promote primary care.
- Eliminating barriers to increased training time in ambulatory care settings for primary care trainees.

The concept of a performance based GME payment system is an idea that is worth exploring. Such a system should be thoughtfully developed and considered in a deliberate way to ensure that goals are achieved without destabilizing the system of physician
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.

Medicare’s current GME payment mechanisms should be replaced with a method that provides a pathway to performance-based GME financing. This transition should be phased in and carefully planned under the guidance of the GME Policy Council, in consultation with the CMS GME Center and GME stakeholders. The Council should ensure that its blueprint for the transition includes a rigorous strategy for evaluating its impact and making adjustments as needed.

ACP recommends the following:

- Measures should be developed by appropriate stakeholders, including physicians involved in GME, especially those involved in primary care training.
- All measures must be carefully developed and thoroughly evaluated before they are implemented.
- Any curriculum related measures should be linked to the well established ACGME competencies and competency based educational reforms already underway.
- Training programs must be allowed adequate time to make necessary changes to their programs before financial incentives are introduced so that they do not risk losing funding at a time when they may need additional resources to meet performance standards.
- Measures must be developed and implemented in a manner that does not systematically advantage or disadvantage certain types of hospitals and training programs, for example large programs, rural programs, community based programs.
- A provision must be in place to evaluate the operation of any performance-based GME payment system at certain intervals to avoid adverse unintended consequences, ensure that the goals of implementing such a system are achieved, and that the measures are still relevant over time. It should not be assumed that simply instituting performance metrics will result in improved medical education and/or progress toward workforce goals.

Staff analysis:
Not all elements of the IOM’s recommendation are consistent with ACP policy.
### Comparison of ACP Policy and IOM Report “Graduate Medical Education That Meets the Nation's Health Needs”

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<th>Recommendation 5: Medicaid graduate medical education (GME) funding should remain at the state’s discretion. However, Congress should mandate the same level of transparency and accountability in Medicaid GME as it will require under the changes in Medicare GME herein proposed.</th>
<th>Relevant ACP policy: GME financing should be transparent, and accountability is needed to ensure that funds are appropriately designated toward activities related to the educational mission of teaching and training residents.</th>
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<tr>
<td>The IOM recommends eventually moving to a performance based GME payment system. The College supports such a concept as long as the measures are thoughtfully developed and evaluated before being implemented. Part of the transformation funds in IOM’s proposal will go toward developing and evaluating such a system.</td>
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<th>IOM on Workforce – while the Committee did not take make any recommendations on workforce, there was significant discussion about physician supply. Below are a few excerpts:</th>
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<td>Although the committee was not charged with projecting the future demand for physicians, it reviewed recent projections and analyses of the capacity of the physician workforce to meet the nation’s health needs. Some projections suggest imminent physician shortages that could prevent many people from getting needed health services. These analyses raise concerns that the rapid aging of the population and the expansion in health coverage resulting from the Patient Protection and Affordable Care Act will fuel demand for physician services far beyond the current capacity. However, the underlying methodologies and assumptions about the future in these studies are problematic. They generally assume historical provider–patient ratios using existing technological supports and thus have limited relevance to future health care delivery systems or to the need for a more coordinated, affordable, and patient centered health care system.</td>
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<td>Relevant ACP policy: A national health care workforce policy is needed to reverse the impending collapse of primary care medicine.</td>
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<td>Staff analysis: Consistent with ACP policy.</td>
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<td>Physician workforce analyses that consider the potential impact of changes and improvements in health care delivery draw different conclusions. These studies suggest that an expanded primary care role for physician assistants and advanced practice registered nurses,</td>
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<td>The College frequently cites a HRSA study on workforce that was published in Health Affairs in 2008 that estimates a shortage of 44,000 primary care physicians by 2025. It is consistent with an AAMC study released at the same time estimating a shortage of 46,000 primary care physicians. AAMC later estimated that health reform will cause an additional 25% shortfall.</td>
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<td>The AAMC, ACP, AMA and many other medical associations have warned of a looming physician workforce crisis and most acknowledge that the shortages in the supply of primary care physicians and general surgeons are most severe. The College has raised concern about the collapse of primary care for several years and has also acknowledged shortages in many IM subspecialties.</td>
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<td>The fact that IOM did not find “credible evidence” to support claims of a looming shortage, particularly in primary care, is troublesome. Waiting until the proposed GME Council completes a more thorough assessment will cause significant delays in the pipeline.</td>
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Comparison of ACP Policy and IOM Report “Graduate Medical Education That Meets the Nation's Health Needs”

The IOM seems to contradict itself when it discusses the need to maintain robust primary care capacity and the possibility of using GME transformation funds to finance new incentives for choosing a primary care career.

redesign of care delivery, and the use of other innovations, such as telehealth and electronic communication, may ultimately lessen the demand for physicians despite the added pressures of the aging population and coverage expansions.

Some stakeholders and policy makers are pushing for significant increases in Medicare GME funding (via an increase in the cap on Medicare-funded residency positions) to ensure the production of more physicians. The available evidence, however, suggests that producing more physicians is not dependent on additional federal funding. The capacity of both medical schools and GME programs has grown considerably during the past decade. Between 2002 and 2012, overall enrollment in U.S. medical schools rose by nearly 28 percent, increasing from 80,180 to 102,498 students. In 2012, 117,717 physicians were in residency training—17.5 percent more than 10 years earlier.

Further increasing the number of physicians is unlikely to resolve workforce shortages in the regions of the country where shortages are most acute, and is also unlikely to ensure a sufficient number of providers in all specialties and care settings.

Concerns that the nation faces a looming physician shortage, particularly in primary care specialties, are common. The committee did not find credible evidence to support such claims. Too many projections of physician shortages build on questionable provider–patient ratios, fail to consider the marked geographic differences in physician supply, and ignore recent evidence of the impacts of more effective organization, new technology, and deployment of health personnel other than physicians (Altschuler et al., 2012; Auerbach et al., 2013a,b; Bodenheimer and Smith, 2013; Ghorob and Bodenheimer, 2012). More conclusive evidence is needed to justify interventions aimed at increasing the number of GME positions at a faster rate than is already occurring.

Regardless of the numbers debate, there is a dearth of successful models for promoting primary care careers and influencing trainees’ career choices. If the GME system is to maintain robust capacity in primary care training and to encourage primary care careers, there
should be a dedicated effort to identify or develop effective interventions. For example, GME funds might be used to finance new incentives for choosing a primary care career. The incentives might focus on the individual trainee by offering medical school loan repayment in exchange for a long-term commitment to primary care practice—on a greater scale than currently provided by HRSA—or else provide incentives to educational institutions that sponsor priority residency programs by paying a substantially higher per-resident amount (PRA) for primary care trainees. No organization currently has the mandate to investigate the utility of such interventions or to develop effective alternatives. Strategic investment in GME cannot be achieved without robust research and demonstration capacity.