August 5, 2014

TO:                 Deans of U.S. Dental Schools
                     Directors of Advanced Dental Education Programs
                     Directors of Allied Dental Education Programs
                     ADEA Board of Directors
                     ADEA Legislative Advisory Committee

FROM:            Richard W. Valachovic, D.M.D., M.P.H, ADEA President and CEO
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RE:                 Institute of Medicine Report on Reforming Graduate Medical Education

On July 29, the Institute of Medicine (IOM) Committee on the Governance and Financing of Graduate Medical Education (GME) released a report titled, *Graduate Medical Education That Meets the Nation’s Health Needs*. The report recommends significant changes to the GME financing and governance system to address current deficiencies.

In the report, the term GME is used to describe the period of residency and fellowship training that is provided to physicians after they receive an allopathic or osteopathic medical degree. Although GME training and funding are also available in dentistry and podiatry, consideration of GME for dentistry and podiatry was outside the scope of the IOM committee's study.

**Background**

As a result of requests for broad reform of the GME system to achieve a greater alignment of financing with the public’s healthcare workforce needs, the Josiah Macy Jr. Foundation and the Association of Academic Health Centers called for an independent external review of the governance and financing of GME, specifically suggesting that the IOM perform the review. In 2012, the IOM formed a committee to conduct the review of the governance and financing of the GME system. Although the 21-member IOM committee has been holding meetings since 2012, the majority of the meetings have been closed to the public. The committee was tasked with evaluating the array of challenges to the governance and financing of GME in the 21st century, which include: a rapidly aging and increasingly diverse patient population; underserved rural and urban populations; growing prevalence of disability and chronic

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1 The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for positions in U.S. GME, the period called residency training. Every state requires at least a year of residency training in the U.S. to receive an unrestricted license to practice medicine. However, most physicians train beyond the minimum requirement to become board certified.

2 To learn more about the role of dentistry in GME, review the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, 100 Stat. 82 (April 7, 1986).

3 In 2012, the Josiah Macy Jr. Foundation asked the IOM to conduct an independent review of the governance and financing of the GME system. Eleven other private foundations provided additional support for the study (the ABIM [American Board of Internal Medicine] Foundation, Aetna Foundation, The California Endowment, California HealthCare Foundation, The Commonwealth Fund, East Bay Community Foundation, Jewish Healthcare Foundation, Kaiser Permanente Institute for Health Policy, Missouri Foundation for Health, Robert Wood Johnson Foundation, and UnitedHealth Group Foundation), as well as the Health Resources and Services Administration (HRSA) and Department of Veterans Affairs (VA). Additionally, eleven U.S. senators, from both sides of the aisle, encouraged the IOM to undertake the study.
disease; an urgent need for a more cost-effective health care system; innovations in health care delivery; impacts of GME on state level policies and GME in state institutions; advances in diagnostics, therapeutics, and health information technology; and others.

Report Overview

The IOM committee identified six goals for an improved GME financing system. These goals shaped the committee’s recommendations for reform. The goals identified by the IOM committee are as follows:

- Encourage production of a physician workforce better prepared to work in, help lead, and continually improve an evolving healthcare delivery system that can provide better individual care, better population health, and lower cost.
- Encourage innovation in the structures, locations, and designs of GME programs to better achieve Goal 1.
- Provide transparency and accountability of GME programs, with respect to the stewardship of public funding and the achievement of GME goals.
- Clarify and strengthen public policy planning and oversight of GME with respect to the use of public funds and the achievement of goals for the investment of those funds.
- Ensure rational, efficient, and effective use of public funds for GME in order to maximize the value of this public investment.
- Mitigate unwanted and unintended negative effects of planned transitions in GME funding methods.

Although, the report fails to call for an increase in the number of residency slots to meet the increased demand for healthcare services as a result of an aging baby-boomer population and the implementation of the Affordable Care Act (ACA), the report makes five recommendations to transform the GME system. The recommendations are highlighted below:

1) Invest strategically:

The majority of public financing for GME (which totaled about $15 billion in 2012) comes from the Medicare program – an estimated $9.7 billion in 2012. The remainder of the funding comes from the following sources: Medicaid – $3.9 billion; the U.S. Department of Veterans Affairs – $1.437 billion; and the Health Resources and Services Administration – $0.464 billion. Additional unreported funding comes from the Department of Defense, state sources, private insurers, and other private sources. Since the bulk of GME funding comes from Medicare and Medicaid, the majority of the recommendations included in the report are targeted toward these two funding sources.

The IOM committee report calls for Medicare GME (both direct and indirect) funding to remain at its current level, with an adjustment for inflation. The IOM committee believes that leveraging the public’s GME investment for greater public benefit depends on secure and predictable funding. According to the report, this goal can best be achieved by keeping federal GME support in Medicare, where it can continue as mandatory, not discretionary, funding. In addition, the report calls for a gradual move to a performance-based system which allows for a payment system that rewards performance, ensures

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4 In 1997, Congress capped the number of Medicare-supported physician training slots. Hospitals may add residents beyond the cap, but cannot receive additional Medicare payments for those trainees. The cap is equal to each hospital’s number of residents in 1996. According to the IOM committee report, this essentially froze the geographic distribution of Medicare-supported residents in 1996. As a result, the report notes that the greatest density of Medicare-supported slots and Medicare GME funding remains in the Northeast region of the United States.

5 Direct payments/ direct GME (DGME): These payments cover a portion of the direct costs of training residents, including stipends, teaching physician and resident salaries and benefits, and educational activity costs. DGME is based on a prospectively determined per-resident amount, weighted FTEs, and Medicare patient load. Indirect payments/ indirect medical education (IME): These payments compensate hospitals for the indirect costs of GME – higher patient care costs due to a more complex patient population and increased costs of specialized services. A portion of these funds are used to cover uncompensated care. Both funding streams (DGME and IME) are directly tied to a hospitals volume of Medicare inpatients. In 2012, IME accounted for $6.8 billion, or 70.8%, of total Medicare GME payments to teaching hospitals. DGME payments totaled $2.8 billion, or 29.2%.
accountability, and incentivizes innovation in the content and financing of GME. The current Medicare GME payment system will be phased out as the new system is implemented.

2) Build an infrastructure to facilitate strategic investment:

The IOM committee recommends establishing a two-part governance infrastructure for federal GME financing. A GME Policy Council in the U.S. Department of Health and Human Services (HHS) Office of the Secretary (OS) would be established and tasked with developing a strategic plan for GME funding; sponsoring research regarding the sufficiency, geographic distribution, and specialty configuration of the physician workforce; developing future policies concerning the distribution and use of Medicare GME funds; and ensuring coordination between federal agencies and accrediting/certifying organizations. The Council will also provide annual progress reports to Congress and the Executive Branch on the state of GME.

In addition, a GME Center would be established within the Centers for Medicare and Medicaid Services (CMS) to manage the operational aspects of GME Medicare funding; the GME Transformation Fund (see recommendation #3 below), including the solicitation and oversight of demonstrations; and the data collection and reporting to ensure transparency in the distribution and use of Medicare GME funds.

3) Create one Medicare GME fund with two subsidiary funds:

The IOM committee recommends allocating Medicare GME funds to two distinct subsidiary funds. A GME Operational Fund would be established 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 consortia, medical schools and universities, freestanding children’s hospitals, integrated healthcare delivery systems, community-based health centers, and other qualified entities.

Additionally, a GME Transformation Fund would be established to finance new training slots (including pediatric residents currently supported by the Children’s Hospital GME 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 payments demonstrations and innovation pilots, and to support other priorities identified by the GME Policy Council.

According to the report, all GME sponsor organizations should be eligible to compete for both innovation grants and additional funding for new training positions.

4) Modernize Medicare GME payment methodology:

The IOM committee recommends replacing the separate Indirect Medical Education (IME) and direct GME funding streams with one payment to organizations sponsoring GME programs based on a national per-resident amount (PRA) (with geographic adjustment). According to the report, 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 assist all population groups.

In addition the IOM committee recommends setting the PRA to equal the total value of the GME Operational Fund divided by the current number of Medicare-funded training slots; redirecting the funding stream so that GME operational funds are distributed directly to GME sponsoring organizations; and implementing performance-based payments using information from GME Transformation Fund pilots.  

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6 The IOM committee states in its report that Medicare GME funds should be distributed to the organizations that sponsor residency programs, not only the teaching hospitals that employ or otherwise rely on residents’ services. The committee further provides that transferring fiduciary control to all sponsoring institutions increases the likelihood that GME funds will flow to and increase training in non-hospital settings.
5) Medicaid GME:

Finally, the IOM committee recommends that Medicaid funded GME remain at the state’s discretion; and that Medicaid funded GME adopt the same accountability/transparency standards as Medicare.\(^7\)

The committee also recommends a 10-year transition from the current GME system to full implementation of its recommendations, followed by a reassessment of the need for continued Medicare GME funding. Specifically, the committee recommends that continued Medicare support for GME be contingent on its demonstrated value and contribution to the nation’s health needs.

**Take Away**

For academic dentistry, if the recommendations are implemented one noted impact will be on IME, it may become obsolete. Instead of parsing between IME and GME, all payments will be distributed through one unified GME fund.

Medicare GME support will remain at the current aggregate level, i.e., the total of indirect medical education and direct graduate medical education in an agreed-on base year and Medicaid graduate medical education funding is recommended to remain at the state’s discretion.

Lastly, the report proposes creating a GME Policy Council in the Office of the Secretary of the U.S. Department of Health and Human Services, the purpose of the council will be oversight, strategic planning, research, and policy development.

The IOM committee “acknowledges that repurposing and redesigning GME funding will be disruptive for teaching hospitals and other GME sponsors accustomed to receiving Medicare and GME monies in the same way for nearly 50 years.” As a result, the committee reiterates that it is recommending a phased-in implementation over a 10-year period to allow a gradual change in the GME system.

**Next Steps**

The rules governing the Medicare GME financing system are rooted in statute, therefore, the IOM committee’s recommendations cannot move forward without legislative action. Thus, the IOM committee report states the following, “the committee strongly urges Congress to amend Medicare law and regulation to begin the transition to a performance-based system of Medicare GME funding.” In light of the requirement that Congress take legislative action to implement these recommendations, it may be quite some time before we see any of these proposals come to fruition.

ADEA will continue to monitor the issue and will critique proposed legislation impacting GME; we will keep members abreast of any Congressional action to codify the report’s recommendations.

As always, please check with your legal counsel to determine how the IOM committee recommendations may impact your institution. If you should require additional information, please do not hesitate to let us know. Contact Yvonne Knight, J.D., ADEA Senior Vice President for Advocacy and Governmental Relations, ADEA Policy Center at KnightY@adea.org.

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\(^7\) Although Medicaid regulations do not specifically recognize GME as an approved component of inpatient and outpatient hospital services, CMS does recognize Medicaid GME. If a state Medicaid program opts to cover GME costs, the federal government provides matching funds. According to the IOM committee report, states have considerable flexibility in how they use Medicaid funds for GME purposes, including which professionals, settings, and organizations are eligible to receive support for health professions education. In 2012, 43 state Medicaid programs, including the District of Columbia, distributed about $3.87 billion to support local GME, primarily sponsored by teaching hospitals.