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THE IOM RECOMMENDS THAT THE CURRENT GME REIMBURSEMENT SYSTEM IS OVERHAULED – ARE YOU PREPARED TO WEATHER THE STORM?

The recent report by the Institute of Medicine on the United States graduate medical education system, *Graduate Medical Education That Meets the Nation's Health Needs*[1] ("IOM Report"), advances many structure reform themes that have appeared in other assessments in recent years. However, it goes much further. The IOM Report calls for fundamental changes to the current graduate medical education ("GME") financing and oversight structure. While only Congress can make the change, the in-depth study and report by the IOM will likely bring GME finance restructuring into the broader discussions on health care delivery system reform.

This article offers a concept review of the major recommendations and analysis in the IOM Report and offers several specific strategic steps that academic medical centers, health care systems and teaching hospitals should take to scope current operations to be prepared to understand and assess the impact of what potential changes might mean for future funding. The bullet points at the end of this article outline steps to prepare for a possible coming storm in GME financing by first establishing a deep understanding of your institution's current circumstances and then accurately and fully portraying them in public documents. Hall Render can assist in performing all of these reviews, as well assessing and implementing the strategic options for needed transformation.

If implemented, the proposals in the IOM Report would initiate fundamental reform of the GME funding structure with unprecedented levels of public policy-based oversight. A new federal governance structure over GME may direct how Medicare funds are used, which physician specialties will be funded (likely more primary care) and which programs will lose funding (likely procedural specialties). The new structure may also focus on better aligning medical education with the location of the physician need, meaning that all regions where Medicare GME payments are currently higher will become lower, if the current perception of geographic and rural/urban misalignment is validated.

The IOM Report recommends that the current GME funding structure be transformed with the following goals: better physicians (competency), better aligned physicians (diversity, the right specialties and cultural competence) and innovation in GME training, transparency and accountability, all within a "smart" system that is performance-based. The IOM Report acknowledges the disruption this reform will create and considers ways to mitigate the disruption by a measured phase-in of reform.

While generally commended for its focus on promoting innovation, transparency and accountability in GME, the IOM Report has also been widely criticized. The Association of American Medical Colleges states that the proposal to "radically overhaul graduate medical education (GME) and make major cuts to patient care would threaten the world's best training programs for health professionals and jeopardize patients, particularly those who are the most medically vulnerable."[2] The American Medical Association "appreciates" the IOM's efforts, but it remains "concerned about the need to recognize the nation's potential physician shortages and the need for adequately funded physician training."[3] Further, the IOM Report also seems to have initiated a broader evaluation of GME itself, where some economists, reportedly including the two economists on the IOM GME panel, question whether GME is even a "public good" that merits taxpayer funding at all, while recognizing that withdrawing the $15 billion in funding "would create shock waves that should perhaps be avoided."[4]

The IOM Report includes some very scathing observations regarding the current funding structure and its outcomes. The IOM makes observations and takes positions to the effect of the following: there is a fundamental misalignment between the rules governing Medicare GME financing and the objectives of a high-value health care system; the IOM does not support continuing Medicare GME reimbursement at the current levels without fundamental reform of the system; and continuing the current system only promotes existing inequities and furthers the negative trends that the current system now represents.

The proposal for reform contained within the IOM's Report would require money to move away from the teaching hospitals to the program sponsors over the next 10 years, maybe sooner. While some teaching hospitals themselves are also the sponsors of the accredited programs, just about as many are not. Even for those hospitals that are the sponsors, a gap commonly exists between those in finance, who each year report the limited Medicare information needed and can identify the total amount of GME reimbursement received, and those in

medical education, who actually spend the money to create the teaching environment. As the IOM Report points out, the current Medicare GME reimbursement structure, for example, only requires very rudimentary data to process state and federal GME payments, and even that limited data goes largely unaudited. So today, while the finance department may know 100% of what is currently needed for Medicare GME reimbursement, that knowledge may be less than is needed to project the impact of the possible changes to come.

Despite its call for large-scale reform, the IOM Report suggests maintaining Medicare GME as part of the Medicare system (so GME funding is linked to an entitlement system that may endure over time) and funding at the current levels (currently about $9.7 billion from Medicare and slightly more than $15 billion in state and federal funding overall). If the total Medicare spend is to remain at current levels, it seems likely that such payments would come with added program accountability and performance validation. Understanding your current GME revenue and costs will leave your system better able to understand and adapt to potential restructuring of the system or reductions in overall GME payments.

While keeping it in the Medicare program, the IOM also endorses delinking GME reimbursement from Medicare patient volume. The reasoning here is that the physician workforce will treat the entire population, not just Medicare patients. The current formula link between Medicare hospital inpatient volume and GME reimbursement was identified by the IOM as having created a misalignment between Medicare GME funding and physician training, disadvantaging the community-based and non-hospital sites where most physicians will practice for the bulk of their careers.

The IOM calls for a new national per resident amount ("PRA") calculated by taking the total current payment in a base year divided by the number of residents trained in that year (accounting for the initial residency period and approved fellowships). The IOM offers a complex and detailed analysis to illustrate a potential combined single PRA of $80,735 (eliminating the direct and indirect duality). While the creation of a single, geographic location adjusted national PRA paid to the sponsoring institution could potentially be a relatively neutral result for teaching hospitals that are also the sponsors of the teaching programs, for teaching hospitals that are not the program sponsors and that are in academic medical centers or consortium structures, the impact could be profound, likely requiring the complete rework of GME administrative arrangements and agreements.

With the observation that current GME structure results are less than optimal or even counterproductive, the IOM proposes to condition the ability to continue to receive GME funding on new performance-based measures, which are established nationally. While the new GME reimbursement will remain part of an individual entitlement plan that is widely expected to endure (Medicare), the receipt of GME funds itself would be based on performance and not just on historical facts. Leaving the details to future panels, the IOM suggests performance metrics based on whether the "right" types of physicians are being trained, population-based needs assessments and whether the graduating physicians are competent in the selected field and diverse enough to meet actual population health care needs.

The current GME reimbursement methodology is criticized for its lack of transparency and accountability. As many experience, opacity begins and seems to commonly exist within the GME structures of health care systems, and this opacity is recognized by the IOM as a fundamental limitation of the current structure, frustrating any efforts at accountability. If the lack of transparency is a big problem, institutions can begin to address that issue for themselves today by better understanding current GME operations and current funding. Even if the current funding is fundamentally changed in the future, knowing the current details will make sure your system is prepared to be able to understand what any proposed changes might mean. Medicare GME reimbursement has been on close to autopilot for a decade or more, and the IOM seems to be saying that there may not even be, or never was, a pilot in the cockpit. Teaching hospitals and health systems need to understand the Medicare Direct Graduate Medical Education and Indirect Medical Education reimbursement, and other GME payments (such as state Medicaid) received today, to have an ability to scope the impact of possible future changes. All institutions gather and report data to claim GME payments and ultimately know the total amount of Medicare and other GME reimbursement they receive. However, few may track the details above and beyond what Medicare requires, to the extent it has no impact on current funding. Given the current autopilot course, that strategy has worked well so far, but when the system flips to full manual controls, the need to be able to take control will quickly become paramount and comprehensive data will be key.

To better understand the potential impact of changes such as those proposed in the IOM Report, as well as others that Congress may decide, we offer the following questions, the answers to which will give your organization a more solid base to assess potential future changes:

- Is it clear at your system how much Medicare GME reimbursement is received, why it is received and where it is spent? If not, now may be the time to do a self-assessment to understand the current state of Medicare GME funding, to have the tools and an available internal

knowledge base to react to possible changes to come and to understand quickly the impacts they may have.

- Is your sponsoring institution structure right for the future? If Medicare GME reimbursement shifts from teaching hospitals to the sponsoring institutions, will the sponsoring institution structure in your system support your programs for the future?
- Is your system accurately and fully reporting all GME costs and all of the resident time being supported, whether the teaching hospitals are ***over their caps*** or not? While maximizing the total appropriate costs and teaching time may not lead to more Medicare reimbursement today because of the full-time equivalent caps and PRA limits, if Congress pushes the reset button on Medicare GME, those who knowingly or unwittingly underreport current costs and resident time may unintentionally set themselves up for lesser future funding if Congress retains some components that link payments to recent history. Make sure all open and future cost reports and Intern and Resident Information System reports include all allowable costs and all appropriate resident time.

While the breadth of details found within the IOM Report are beyond the scope of this article, a specific proposal worth noting involves the establishment of two funds within a new GME funding structure, one to fund operations and a second to fund transformation and innovation. While the geo-adjusted PRA may fund core operations to sustain what will be, for a time, the continuation of the status quo, the new transformational fund will redirect a portion of what is currently paid in new ways that are scaled to performance criteria intended to improve the physician output from the system to meet local, regional and national health care needs. The next 20 years of GME funding may look very different than the last 20 years.

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[1] *Graduate Medical Education That Meets the Nation's Health Needs Institute of Medicine of the National Academies*, Committee on the Governance and Financing of Graduate Medical Education, (Jill Eden, Donald Berwick et al., eds., 2014) downloadable here.

[2] *IOM's Vision of GME Will Not Meet Real-world Patient Needs*, Association of American Medical Colleges, statement issued by AAMC President and CEO, Darrell G. Kirch, M.D. (July 29, 2014) available here.

[3] *AMA Urges Continued Support for Adequate Graduate Medical Education Funding to Meet Future Physician Workforce Needs,* statement issued by AMA Immediate Past President, Ardis Dee Hoven, MD. (July 29, 2014) available here.

[4] Uwe E. Reinhardt, *The Teaching of Future Doctors Doesn't Necessarily Deserve Your Tax Dollars,* N.Y.Times, Aug. 22, 2014, available here.