# The IOM Report on GME and Physician Workforce Projections:

An Overview and Discussion

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## The Three-Part Mission of Academic Medicine Advances Health and Health Care

### Extraordinary Clinical Care

- **AAMC hospitals comprise only 5% of all hospitals but account for:**
  - ✓ 37% of charity care
  - ✓ 22% of all inpatient admissions
    - 25% of all Medicaid in-patient days
    - 18% of all Medicare in-patient days
- **88,577 full-time MDs work in medical school clinical departments**

### Cutting Edge Research

- **Over half of NIH extramural awards support research at AAMC-member hospitals or member medical schools**

### Education and Training

- **74% of all residents train at an AAMC hospital**

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## Guiding Principles on GME

**Best carried out in an environment that is…**

- **Team-focused.** Learners interact with a variety of medical specialties and other health professions.
- **Focused on core competencies.** There is significant educational infrastructure, oversight for teaching, and evaluation of ACGME core competencies.
- **Engaged with research.** Faculty are engaged in expanding medical knowledge through clinical research.
- **Multi-faceted.** Learners interact regularly with a diverse array of patients, conditions, and care settings throughout the community.
- **Focused on care innovation.** There is ongoing innovation in clinical care delivery and commitment to quality improvement and patient safety.

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## Physician Workforce Projections

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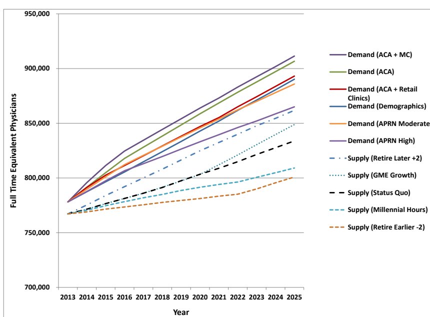
## Supply Versus Demand: *All Physicians*




**Source:** *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025.* Prepared for AAMC by IHS, Inc. March 2015. https://www.aamc.org/download/426248/data/thecomplexitiesofphysiciansupplyanddemandprojectionsfrom2013to2.pdf

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## Projections for 2025

**Overall Shortage:**
**46,000 – 90,000 physicians**

Shortage in Primary Care:
12,500 – 31,100 physicians

Shortage in Medical Specialties:
5,100 – 12,300 physicians

Shortage in Surgical Specialties:
23,100 – 31,600 physicians

Shortage in Other Specialties:
2,400 – 20,200 physicians

**Source:** *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025.* Prepared for AAMC by IHS, Inc. March 2015. https://www.aamc.org/download/426248/data/thecomplexitiesofphysiciansupplyanddemandprojectionsfrom2013to2.pdf

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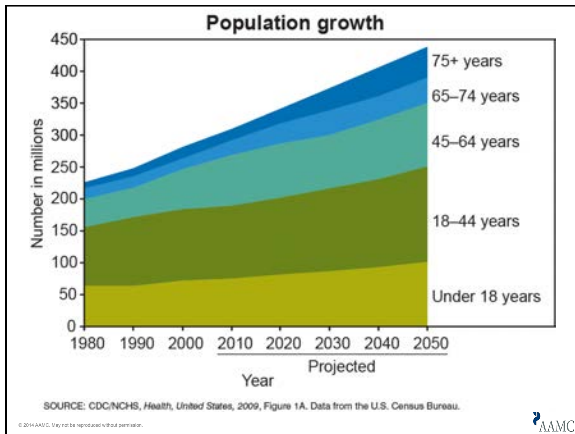

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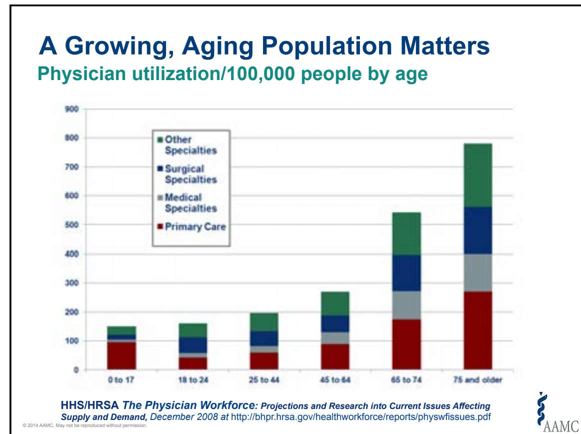

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# The IOM Report

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## AAMC's Response

IOM:
https://www.aamc.org/download/421856/data/aamcresponsetoiomreportongme.pdf

E&C:
https://www.aamc.org/download/421894/data/aamcrespondstoenergyandcommercerequ

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## From the Report: Illustration of Impact

TABLE F-3 Illustration of Impact of Changing to Combined PRA

| | Number of Hospitals | Total Weighted DGME Count | Current DGME Payments (millions) | Current IME Payments (millions) | Consolidated PRA Payments (millions) | Current Average Payment per Resident | Change in Average Payment per Resident | Percentage Difference in Payment Attributable to IME Reduction | Percentage Difference in Payment Attributable to Other Changes |
|---|---|---|---|---|---|---|---|---|---|
| All hospitals | 1,016 | 76,247 | $2,924 | $7,097 | $6,633 | $131,428 | $(44,435) | −34% | 0% |
| Number of residents | | | | | | | | | |
| <10 | 270 | 1,269 | $52 | $114 | $100 | $131,365 | (52,496) | −32% | −8% |
| 10–99 | 488 | 15,278 | $701 | $1,509 | $1,260 | $144,645 | (62,177) | −32% | −11% |
| 100–249 | 136 | 17,861 | $735 | $1,651 | $1,560 | $133,586 | (46,246) | −33% | −2% |
| 250–499 | 84 | 23,366 | $790 | $2,042 | $2,057 | $121,183 | (33,149) | −34% | 7% |
| 500 or more | 38 | 18,475 | $645 | $1,781 | $1,656 | $131,372 | (41,733) | −35% | 3% |
| Medicare share quintile | | | | | | | | | |
| 1: < 38.2 percent | 203 | 29,643 | $727 | $1,974 | $2,600 | $91,106 | (3,393) | −35% | 33% |
| 2: 38.2 to < 44.6 percent | 203 | 21,591 | $896 | $2,227 | $1,893 | $144,643 | (56,857) | −34% | −5% |
| 3: 44.6 to < 51.3 percent | 203 | 12,111 | $585 | $1,329 | $1,040 | $158,044 | (72,180) | −33% | −13% |
| 4: 51.3 to < 58.1 percent | 203 | 7,109 | $377 | $840 | $611 | $171,133 | (85,246) | −33% | −17% |
| 5: >= 58.1 percent | 204 | 5,794 | $340 | $726 | $487 | $184,124 | (100,055) | −32% | −22% |
| Medicare discharge quintile | | | | | | | | | |
| 1: < 1,940 discharges | 203 | 6,140 | $145 | $276 | $533 | $68,573 | 18,167 | −31% | 58% |
| 2: 1,940–3,558 discharges | 203 | 10,039 | $339 | $625 | $891 | $96,081 | (7,374) | −31% | 23% |
| 3: 3,559–5,169 discharges | 203 | 10,529 | $414 | $819 | $906 | $126,684 | (40,675) | −33% | 0% |
| 4: 5,170–7,684 discharges | 203 | 16,494 | $592 | $1,553 | $1,421 | $150,061 | (43,914) | −34% | 1% |
| 5: > 7,684 discharges | 204 | 33,046 | $1,434 | $3,722 | $2,683 | $156,039 | (68,765) | −34% | −10% |

**Source:** IOM (Institute of Medicine). 2014. *Graduate medical education that meets the nation's health needs.* Washington, DC: The National Academies Press.

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## Congressional Intent for IME Payments

"This adjustment is provided in light of doubts … about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents … The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals."

*- House Ways & Means Committee Rept. No. 98-25, March 4, 1983, and Senate Finance Committee Rept. No. 98-23, March 11, 1983*

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## Sample Mission-Related, IME-Supported Patient Care Services

| Mission-Related Patient Care and Community Services | COTH Teaching Hospitals | Federally Qualified Health Centers (FQHCs) | Other Ambulatory Settings |
|---|---|---|---|
| Lung Transplant Programs? | ✓ (87%) | X | X |
| Liver Transplant Programs? | ✓ (85%) | X | X |
| Heart Transplant Programs? | ✓ (78%) | X | X |
| Level 1 Trauma Centers? | ✓ (79%) | X | X |
| Bone Marrow Transplant Programs? | ✓ (68%) | X | X |
| Burn Units? | ✓ (68%) | X | X |
| Joint Commission Advanced Certification Comprehensive Stroke Centers? | ✓ (74%) | X | X |
| 24/7 Stand-by Services for Critically Ill or Injured Patients? | ✓ | X | X |
| Equipped and Staffed to Accept Transfers of Complex, Medically Vulnerable Patients? | ✓ | X | X |
| Incur Additional Costs Related to the Above Services? | ✓ | X | X |
| **Eligible for IME Payments?** | **YES** | **NO** | **NO** |

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## Themes and Alternative Strategies

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## Themes from the Report

- **Implications of Medicare support.** Extending the stability of Medicare funding to other training programs.
- **Training in community-based settings.** Increasing support to community-based and ambulatory settings.
- **Maldistribution.** Addressing geographic distribution of training programs and graduates.
- **Evaluating shortages and specialty composition.** Determining and addressing future shortages of physicians in areas of greatest need.
- **Transparency and accountability.** Enhancing transparency of GME funds and accountability for training the workforce to meet future health care needs.

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## Implications of Medicare Support

Tying Medicare GME payments to an institution's Medicare volume ensures Medicare pays only its share of the costs.

Other payers contribute little to no explicit funding to offset the costs of physician training and unique clinical missions.

### Alternatives the Committee Could Have Explored

Augmenting existing support with contributions from other payers (e.g., "all-payer").

Stabilizing funding for existing federal programs outside of Medicare. For example:

- Title VII (e.g. Primary Care Residency Expansion program)
- Children's Hospitals GME

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## Community-based Settings: What if hospital DGME payments were like community-based DGME?

| | Teaching Hospital at/below cap (Cap: 25, FTE: 25) | Teaching Hospital above cap (Cap: 25, FTE: 40) | Teaching Hospital paid like FQHC/RHC (FTE: 25) | Teaching Hospital paid like CAH (FTE: 25) |
|---|---|---|---|---|
| DGME cost/ resident | $152,000 | $152,000 | $152,000 | $152,000 |
| Medicare Share (% of bed days) | 40% | 40% | 40% | 40% |
| Medicare Reimb./ Resident | $41,480 | $41,480 | $60,800 | $61,408 |
| Total DGME Costs for All Residents | $3.800 million | $6.080 million | $3.800 million | $3.800 million |
| Total Medicare DGME Reimb. | $1.037 million | $1.037 million | $1.520 million | $1.535 million |
| **Percent of DGME Costs Recovered** | **27%** | **17%** | **40%** | **40.4%** |

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## Community-based Settings

Federally qualified health centers (FQHC), rural health clinics (RHC), and critical access hospitals (CAH) are currently eligible for DGME.

The level of DGME funding they receive from Medicare simply corresponds to their (generally low) Medicare volume.

### Alternatives the Committee Could Have Explored

Augmenting existing support with contributions from other payers.

- Expansion of Medicaid GME support?

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## Maldistribution

Caps for rural hospitals allowed room for growth and rural hospitals can expand their caps to add new residency programs. Caps do not apply to CAHs.

Other hospitals can become "new" teaching hospitals.

**Alternatives the Committee Could Have Explored**

Medicare Rural Training Track (RTT) program:

- Incentivizes partnerships between urban hospitals and rural hospitals and non-hospital clinical settings.
- Residents must train at the rural site for over half their training.

Start-up funding to non-teaching hospitals?

The role of factors unrelated to training such as clinical reimbursement and the practice environment.

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## Evaluating Shortages and Specialty Composition: Validity of Workforce Projections

Transformation of the delivery system holds much promise, but it will take time, and its course (and effect on utilization) is largely unknown.

In the meantime, the "knowns" include an aging population requiring greater health care services across disciplines.

**Alternatives the Committee Could Have Explored**

AAMC-supported legislation would address only a fraction of projected shortages, relying on other reforms to address the remainder. No single approach is sufficient on its own.

Factors other than GME financing "are far more important" in influencing "the makeup and productivity of the physician supply."

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## Transparency & Accountability

**AAMC-supported legislation aligns with the report's transparency and accountability recommendations.**

**Transparency**

H.R. 1201 directs HHS to issue an annual report on Medicare GME payments, including data on:

- DGME & IME payments to each hospital;
- DGME costs of each hospital, as reported on Medicare cost reports;
- Number of FTEs at each hospital counted for DGME/IME purposes;
- Number of FTEs at each hospital not counted for DGME/IME; and
- Factors contributing to higher patient care costs at each hospital, including:
  - Costs of trauma, burn, and other stand-by services;
  - Provision of translation services for disabled/non-English speaking patients;
  - Costs of uncompensated care;
  - Financial losses with respect to Medicaid patients; and
  - Uncompensated costs associated with clinical research.

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**Accountability**

H.R. 1201 directs HHS to implement IME payment adjustments based on whether a teaching hospital trains residents in:

- A variety of clinical settings and systems;
- Multispecialty and interprofessional teams;
- The relevant cost and value of diagnostic & treatment options;
- The delivery of evaluation and management (vs. procedural) services; and
- Other "patient care priorities."

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