Medicare’s Graduate Medical Education Policy: Its Inception and Congress’s Clear and Persistent Commitment
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Acknowledgments

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Introduction

Since Medicare’s enactment in 1965, Congress has repeatedly affirmed the need to reimburse hospitals for graduate medical education (GME). It has maintained separate payments for direct and indirect GME, financed by guaranteed funding that can only be stopped through legislation and that is paid directly to teaching hospitals. This paper summarizes the history of the Medicare GME reimbursement policy and the factors important to the ongoing debate about that policy. For a summary of pivotal reports and legislation over the past 50 years, see Table 1.

The July 2014 release of the report “Graduate Medical Education That Meets the Nation’s Health Needs” rekindled the perennial discussion about the future of Medicare policy on reimbursing the cost of teaching hospitals’ GME.\(^1\) In that report, the Institute of Medicine’s (IOM’s) Committee on the Governance and Financing of Graduate Medical Education recommended

- Continuing funding adjusted only for inflation,
- Eliminating separate direct graduate and indirect medical education (DGME and IME) payments coupled with reallocating funds to more purposes,
- Creating new bureaucracies,
- Delinking GME payments from Medicare service,
- Establishing accountability for the results of GME funding, and
- Effectively reducing major teaching hospitals’ Medicare GME payments significantly.

Leaders of the IOM committee and the Association of American Medical Colleges (AAMC) have debated the IOM report’s recommendations on Capitol Hill, before the media, and at conferences of academic and professional organizations, and they have responded to requests for feedback about the report from the House Energy and Commerce Committee.\(^2\) This is only the most recent wave of policy discussions on this complex topic. Since Medicare’s enactment, countless studies and articles have addressed a variety of questions about GME funding, including the ones being discussed today: Should Medicare GME payments be further reduced? Should Medicare IME payment funds in particular be used for other purposes? Should Congress lift the 1997 cap, which limited the number of residents for which a hospital is eligible for GME payments to the number the hospital had at the end of 1996? Should portions of Medicare GME support be redirected to expand primary care training? Should nonhospital training sites receive GME payments? Should hospitals or residents bear more of GME’s cost? How should Medicare GME payment recipients be held accountable for GME’s outcomes?

Teaching Hospitals Face Multiple Medicare Payment Cuts

With billions of federal dollars at stake and more and more advocates laying claim to Medicare GME funding, the debate about GME funding can be heated.\(^3\) It is also intense because the way federal policymakers respond to this issue could mark a turning point for all of academic medicine, which includes GME and research. Teaching hospitals’ significant revenues have made them essential sources of funding for academic medical center missions that do not pay for themselves, including biomedical research, training, and standby capacity (that is, staffing and equipping facilities such as trauma centers, pediatric intensive care units, and burn units that most hospitals cannot afford and are not equipped to provide).\(^4\)

All hospitals face a growing number of Medicare and Medicaid payment cuts due to federal budget tightening, value-based purchasing initiatives, and other reimbursement reforms, as well as to the implementation of payment reductions required by the Patient Protection and Affordable Care Act (ACA).\(^5\) The prospect of additional payment cuts in Medicare GME would be highly problematic for teaching hospitals, for the health systems and medical schools they work with, and for the communities they serve.

AAMC analysis suggests that even without potential Medicare GME cuts, by 2023, major teaching hospitals could face a reduction of nearly 15 percent of their Medicare revenues because of the FY 2015 regulatory changes in Medicare inpatient reimbursement.\(^6\) In addition, according to the March 2014 Medicare Payment

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Advisory Commission (MedPAC) report to Congress, from FY 2007 to FY 2012, Medicare inpatient payments “were 5 percent to 7 percent below allowable Medicare costs, with an industry-wide Medicare margin of –5.4 percent in 2012.” By 2015, even “efficient” hospitals would experience declines in the already low Medicare margins of 2 percent in 2011 and 2012.7

The combination of reimbursement pressures that teaching hospitals face poses challenges not only for their teaching missions but also for their research and patient care missions, all of which are intertwined. The challenges include the ability to sustain the high-cost services they disproportionately provide, whether they be standby capacity or services to patients requiring public assistance or charity care.

Many factors shape the debate about Medicare GME funding, such as the changing health care landscape, federal and state budget politics, and competing visions of federal funding for physician training. The 50-year history of Congress’s enactment and amendment of GME policy plays a key role in the debate, too, since changing Medicare policy often requires Congress to act. The next section documents the long-standing clarity of the policy’s legislative history and the persistent bipartisan support for Medicare GME, created to help ensure that senior citizens have access to health care.

Legislative History

At this defining moment in Medicare GME policy, we focus on just one factor: the policy’s legislative history—specifically, how clearly Congress recognized in the original enactment of Medicare the importance of paying the extra costs of teaching hospitals in order to ensure seniors’ ability to access the care they need through Medicare and how persistently Congress has retained that recognition over five decades.

The failure of public and private sectors to fulfill the congressional expectation of a shared responsibility has left GME and, by extension, teaching hospitals and the patients they serve vulnerable to recurring economic downturns and their destabilizing consequences. Repeated amendment of Medicare GME policy has coincided largely with efforts to arrest federal budget deficits, not with efforts to fulfill a coherent vision of the needs of the national health workforce or of how to sustain teaching hospital services.

Congress Recognized the Importance of GME from the Start

Providing health coverage for seniors was under consideration for decades before Medicare was enacted with P.L. 89-97, the Social Security Amendments of 1965, which added Title XVIII to the Social Security Act. Medicare legislation passed because Congress was able to blunt opposition from influential provider groups by making sure they would not oppose its reimbursement policy. To do that, Congress established cost-based reimbursement, which would pay what providers billed Medicare—their “reasonable” costs—subject to annual audits.8 This guaranteed that Medicare would cover teaching hospitals’ mission-related costs of specialized care, research, and education.

Congress offered an explicit commitment to GME. Using identical language in reports explaining their legislation, the relevant Senate and House committees specified the importance of compensating hospitals for DGME costs:

“Many hospitals engage in substantial educational activities, including the training of medical students, internships and residency programs. . . . Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs, in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program.”9

Robert A. Berenson, acting deputy administrator of the Health Care Financing Administration (HCFA, the 1977 successor to the Social Security Administration that originally administered Medicare and the predecessor to the 2001 agency that administers Medicare today, the Centers for Medicare and Medicaid Services), reflected this view when he explained in the Federal Register on January 12, 2001:
“Since the inception of Medicare in 1965, we have recognized an obligation to share in the costs of educational activities sponsored by participating providers until the community at large chose to bear them in some other manner. Medicare has historically reimbursed providers for the program’s share of costs associated with approved educational activities . . . [that] may be broken down into three general categories. . . . [First] Approved graduate medical education activities . . . .”

Looking back on Medicare’s early years, Eric Munson, executive director of University of North Carolina Hospitals, testified to Congress in March 1995:

“Until the mid-1980s, Medicare paid for its share of DGME costs based on the hospital’s historical and reasonable costs, as determined by an audit. Reimbursement was open-ended in that a proportionate share of ‘reasonable and allowable’ DGME costs incurred every year was ‘passed through’ to the Medicare program.”

**Cost-Containment Efforts Affected GME Reimbursement Policy**

Cost-based reimbursement may have deflated provider opposition to Medicare’s enactment, but it sowed the seeds of unchecked spending. Within a few years, the Nixon administration and Congress recognized the need to impose cost containment to slow the growth in Medicare spending. Payments to hospitals were increasing annually by double-digit percentage points.

With the enactment of Sec. 223 of P.L. 92-603, the Social Security Amendments of 1972, Congress gave the Executive Branch the authority to take the first steps toward a prospective payment system (PPS) that would give incentives to providers to control their costs. Specifically, Sec. 223 authorized the Executive Branch to deny reimbursement for “unreasonable” costs, which the Social Security Administration translated into “routine service limits” on reimbursement for the costs of nursing and room and board considered common among hospitals.

The Social Security Administration began to implement the limits in the mid-1970s. However, the Administration carved out reimbursement for DGME from these spending restraints. As Medicare spending continued to grow during the 1970s, the Executive Branch tightened the routine service limits—linked to market rates—and it not only retained its DGME adjustment but also added an IME adjustment. In 1980, HCFA established a formula for calculating an IME adjustment in recognition of the fact that teaching hospitals incur legitimate and unique additional patient care costs that nonteaching hospitals do not. (Thirty-five years later, these DGME and IME adjustment formulas remain in effect, although the actual reimbursement amounts have changed many times over the years.)

The tightening of the routine service limits did not contain costs sufficiently. Consequently, in 1982, in Sec. 101(c) of P.L. 97-248, the Tax Equity and Federal Responsibility Act (TEFRA), Congress called for the Department of Health and Human Services (DHHS) secretary—consulting with the relevant congressional committees—to submit a report proposing legislation to establish a new PPS. In mid-December 1982, the secretary submitted his “Report to Congress—Hospital Prospective Payment for Medicare.” It outlined a PPS based on diagnosis-related groups (DRGs) and included DGME and IME adjustments derived from the formulas used as part of the Sec. 223 limits.

The secretary recommended that “the direct costs of approved education programs should be excluded from the [DRG] rate and be reimbursed as per the present system.” With respect to indirect costs, he said, “The indirect costs of graduate medical education are the higher patient care costs incurred by hospitals with medical education programs. . . . Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals. . . . [N]ot wanting to penalize these hospitals, an adjustment methodology has been developed . . . . [DHHS] believes that recognition of these indirect costs should be accomplished through a lump sum payment, separate and distinct from the base rate. . . . The adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total limits for graduate medical education . . . .”
Because DHHS developed the report in consultation with the committees, the agency expected that Congress would include DGME and IME adjustments in the PPS legislation enacted in Title VI of P.L. 98-21, the Social Security Amendments of 1983. Before the bill’s mark-up, the Senate Finance and House Ways and Means Committees were intent on identifying a numerical value for the IME add-on percentage in the preexisting IME formula. They wanted to ensure that teaching hospitals would not experience untoward losses under the new system. They also wanted to reduce the appearance of inequitable reimbursement among hospitals, states, and regions. Ultimately, at the recommendation of the DHHS assistant secretary for planning and evaluation, which was based on a Congressional Budget Office report, Congress simply doubled the IME add-on percentage—from 5.79 to 11.79 percent—for each 10 percent increase in a hospital’s ratio of the number of interns and residents to the number of beds, or the intern/resident-to-bed ratio (IRB).18

During Senate floor debate on March 16, 1983, Finance Committee Chairman Robert Dole (R-Kan.) highlighted the bill’s IME adjustment:

“For example, on the issue of severity of illness, we know that certain institutions, many of which are teaching hospitals, care for patients that are far sicker than the average patient and consume a greater number of resources. A DRG payment may not be sufficient in these cases. To help adjust for this concern, the provision agreed to by the Finance Committee contains two adjustments for teaching institutions. The first recognizes the direct costs of teaching—salaries, blackboards—and passes these costs through. The second recognizes the indirect costs of teaching and doubles the current adjustment for these costs.”19

Congress was fully aware that unlike DGME, Medicare’s IME adjustment was paying for the higher cost of patient care, not medical education. It was, in the words of the House committee, a “proxy” for the payment shortfall that the DRG-based PPS produced in teaching hospitals when the reimbursement rate was not adjusted.20 The Ways and Means Committee said, “Your Committee strongly believes in the importance of providing this [IME] adjustment in light of serious 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. . . . [T]he adjustment for indirect medical education costs is only a proxy [emphasis added] to account for a number of factors which may legitimately increase costs in teaching hospitals. . . .”21

Congress’s retention of an IME adjustment that began with the Sec. 223 limits in the early 1980s has become a staple of Medicare GME reimbursement, accounting, on average, for about two-thirds of GME payments to teaching hospitals. However, almost from the beginning, the use of the label “IME” has given the misleading impression that the adjustment is for “education” activities. In fact, it is compensation for the higher costs—or what some would call special “infrastructure” requirements—associated with the complex missions of teaching hospitals that DRG payments did not take into account.22 Unfortunately, this mistaken view of IME has been used to justify efforts to redirect IME payment funding for “other” educational activities, such as recommending that IME funding be eliminated and used instead to pay for more primary care training or GME payment reforms.23

What the Legislative History Tells Us

Politically, enactment of the Medicare DRG-based PPS, including continuation of GME adjustments used with Sec. 223 limits, was bipartisanship at its best, a result of broad support. A Republican administration proposed it, a Democratic House and a Republican Senate refined it, and President Reagan signed it into law on April 30, 1983, only four months after DHHS proposed the PPS.

We have drawn three key observations from this history:

1. In enacting Medicare, Congress explicitly recognized, without qualification, the necessity of Medicare’s paying its fair share of hospitals’ GME costs.
2. For all the changes it has made in Medicare since 1965—from cost-based reimbursement to a diagnosis-related group-based prospective payment system (DRG-based PPS) for inpatient care—Congress has sustained the fundamentals of its GME policy. Lawmakers have consistently held that separate payment adjustments for DGME and IME should be paid directly to the hospitals using guaranteed funding that can be interrupted only by Congress.

3. From the start, Congress saw Medicare’s role in financing GME as a responsibility shared with all payers. It did not envision that Medicare would become singularly influential in residency training by virtue of its dominant financing role.

### Congress Has Remained Committed to GME Adjustments but Not to the Original Funding Levels

Congressional commitment to DGME and IME has endured since 1972 despite many changes over the past 43 years, including many amendments to Medicare since 1983. For example, Congress has repeatedly revised the numerical value of the percentage add-on in the IME formula (for example, with P.L. 106-113, the Balanced Budget Refinement Act of 1999), from a high of 11.59 percent to the current 5.5 percent. It has capped the number of residents for which a hospital may receive DGME and IME payments (P.L. 105-33, the Balanced Budget Act of 1997) and weighted each hospital’s resident count for calculating DGME payment amounts to discourage the training of subspecialists (P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act, or COBRA, of 1985). COBRA also changed the DGME formula from one based on a hospital’s costs to a prospective per-resident amount. These amendments were often part of larger efforts to contain overall Medicare spending.

But Congress retained both the GME and IME formulas decade after decade, never fundamentally restructuring them. DGME adjustments remain a pass-through payment determined by a hospital’s historic per-resident amount, its resident full-time-equivalent count, and the proportion of its inpatient care devoted to Medicare patients.

The purpose of the IME adjustment to the base DRG payment is still to help cover the special infrastructure costs related to teaching hospitals’ and health systems’ unique missions, which the PPS does not take into account—just as outlier and disproportionate-share adjustments make up for other PPS shortcomings. In turn, Congress’s adjustments reflect the fact that GME produces what some have called “joint goods” (that is, research, patient care, education, and societal support that come from being a teaching institution), and there is no accepted empirical method of accounting for the individual costs that each good incurs. That has led to the arbitrary cost accounting that the IME payment formula represents.

Despite this complexity, the amount of a hospital’s IME adjustment continues to be determined as it was more than 30 years ago: by the hospital’s intern/resident-to-bed ratio and its Medicare-patient volume. It reflects Congress’s understanding that under Medicare, teaching hospitals do not receive adequate reimbursement for their unique costs, unlike community health centers and other providers that receive cost-based payment (but not IME adjustments). The IME formula also reflects the determination of policy makers to lessen the long-standing differences in the magnitude of per-hospital GME payments among states.

Throughout the law’s history, Congress has been cautious about changing Medicare reimbursement policy. Even with the DRG-based PPS, a major change, Congress carefully phased it in over four years. The continuation of GME reimbursement adjustments, even as Congress reduced them, can be understood best in light of this history of restraint.

As an aside, it is worth noting that as important as explicit GME reimbursement is to residency training, overall Medicare reimbursement also affects training. In his history of GME, Kenneth Ludmerer observes that after it was adopted in 1983, the DRG-based PPS increased the new, competitive market in which not all hospitals were able to admit a large enough volume of patients to remain profitable. “Prospective payment immediately altered the institutional contour of residency training,” he wrote, by accelerating “the trend for
residency training to concentrate in large, highly specialized ‘tertiary care’ medical centers, already under way . . . .” In other words, PPS made caring faster for more patients who are sicker the norm for residency training.30

**One Reason Medicare GME Policy Is the Way It Is**

To fully understand Medicare policy and how Congress has sought to fulfill the public good of ensuring that all seniors have access to the health care they need, it is important to recognize that the congressional committees responsible for Medicare do not have jurisdiction over physician workforce policy overall. They do have jurisdiction over both the largest federal entitlements, including Medicare, and tax law, so the Senate Finance and House Ways and Means Committees play key roles in budget policy.31 Annual budget deficits—and the recurring need to find entitlement savings—have compelled many of the committees’ actions on Medicare. (Notable exceptions that significantly increased Medicare spending are the enactments of “catastrophic coverage” in 1988, which was repealed in 1989, and of prescription drug coverage in 2003.) Although advocates for either side, whether changing or preserving Medicare GME, may frame their recommendations in terms of workforce policy, the committees make decisions in the context of needing to restrain spending.

In other words, Medicare GME policy was written in committees steeped in the complexities of federal finance and budgeting, not in the intricacies of the physician workforce, academic medicine, and the role GME plays in shaping both. As a result of this history, Medicare GME policy does not have several features that might otherwise be expected:

- **Clear Distinction between Federal Financial Responsibilities for Graduate Medical Education and Clinical Expenses.** Instead of using the misnomers of “direct” and “indirect” GME, federal policy would clearly identify the government’s responsibilities for its share of the education expenses of teaching hospitals and of other entities serving patients whose care is financed with federal funds. The policy would separately identify federal responsibilities for the government’s share of the added clinical costs of teaching hospitals, in the same way it has established financial responsibility in Medicare reimbursement for the government’s share of the added costs of hospitals that serve a disproportionate share of low-income patients, outlier patients needing exceptionally high-cost care, and rural patients.

- **Coordinated, Comprehensive Approach to Graduate Medical Education.** Both Congress and the Executive Branch would have a regularly updated and comprehensive understanding of the multiple facets of the nation’s academic medical enterprise, including workforce development; specialized regional, national, and international care delivery; and both biomedical and health services research. Medicare GME policy would exist within a coordinated approach for all federal programs that affect academic medicine.

- **Commitment to Flexibility in Ensuring that Health Care Needs Are Met.** Because GME policy has such a significant impact on academic medicine, policymakers would be guided by a recognition of the dynamic nature of the health care industry overall and its workforce in particular. They would seek to ensure that any policies affecting the workforce in general or GME in particular would be flexible and adaptable. They would balance a commitment to efficiency and effectiveness with an understanding that too lean a workforce could jeopardize lives, as the Department of Veterans Affairs 2014 wait-time crisis demonstrated.32

- **Effective Accountability and Transparency.** GME payments would go only to the entities that bear the costs of teaching. In consultation with the health care community, including academic medicine, Congress would establish a transparent process for the development, selection, application, evaluation, and ongoing refinement of accountability measures for GME payments.
Shared Responsibility. Financing GME would be a “shared” responsibility of all private and public payers, including Medicare, such as with a trust fund financed by dedicated, stable, and predictable revenues. The AAMC, as well as others within academic medicine, and congressional champions in both parties have supported such an approach since the 1990s.

In today’s political environment, with its focus on cutting rather than expanding federal spending, including Medicare, congressional action on these issues might seem a quixotic quest. There have been times, however, when Congress showed both the vision and the bipartisan will to systematically address federal policy affecting GME. For example, Sen. Daniel Patrick Moynihan (D-N.Y.) sponsored in 1996, 1997, and 1999 the Medical Education Trust Fund Act, and Sen. Jack Reed (D-R.I.) introduced the bill in 2001. It would have established an all-payer trust fund financed by contributions from Medicare, Medicaid, and a 1.5 percent tax on health insurance premiums, generating $17 billion annually. In 1999, Reps. Nita Lowey and Louise Slaughter (D-N.Y.), as well as Reps. Ken Bentsen (D-Texas) and Ben Cardin (D-Md.), introduced similar bills.33

In a 1997 floor statement, Sen. Moynihan called medical schools and teaching hospitals “national treasures.” He said, “The fiscal pressures of a competitive health market are increasingly closing off traditional implicit revenue sources that have supported medical schools, graduate medical education, and research.”34

There have also been periods of solid Republican leadership and support for an all-payer trust fund. H.R. 2491, the Balanced Budget Act of 1995, passed the House on October 19, 1995, and the Senate on October 28, 1995. The bill included a Teaching Hospital and Graduate Medical Education Trust Fund, championed by Ways and Means member Bill Archer (R-Texas). It was composed of five funds—three financed by appropriated general revenues and two by Medicare. The trust fund did not survive after President Clinton vetoed the larger bill for unrelated reasons. Beneficiaries were to be teaching hospitals and qualified GME consortia.35

Yesterday’s champions of ambitious initiatives are gone for the most part, and the times have changed. Today’s Congress is preoccupied with different priorities, including how to meet projected national and regional shortages of both primary care physicians and specialists36 while grappling with intense deficit politics. In an ideal world, a well-coordinated federal policy on academic medicine—including undergraduate and graduate medical education, as well as financing for research and patient care—would be built on an understanding of the distinction between education and clinical expenses, a commitment to flexibility, effective accountability, and shared responsibility.

Conclusion

In the world where GME policy plays out, both Congress and advocates should keep in mind the long-standing, bipartisan support Medicare GME policy has enjoyed. This policy has been motivated by the need to ensure that Medicare would enable seniors to access the care they need, including that provided by teaching hospitals.

End Notes


3. In 2014, there were several proposals to redistribute Medicare GME funding. For example, the IOM Committee on the Governance and Financing of Graduate Medical Education proposed ending separate IME funding, reallocating up to 30 percent of annual Medicare GME funding to new purposes, and no longer tying Medicare GME payments in part to hospitals that have a larger portion of their patient care financed by Medicare. The American Academy of Family Physicians recommended folding Medicare IME payments into Medicare DGME funds to pay only for training for first certificate residency programs. Sen. Patty Murray (D-Wash.) sponsored S. 2728, the Community-Based Medical Education Act, to reallocate a percentage of Medicare IME funding for purposes other than IME.


35. Sec. 12501 of H.R. 2491, the Balanced Budget Act of 1995, would have created a new Title XXII of the Social Security Act, which authorized the establishment of the Teaching Hospital and Graduate Medical Education Trust Fund.

Table 1. History of key graduate medical education (GME) reports and legislation. Since the publication of the seminal “Flexner Report” in 1910, numerous reports and other publications have shaped GME and expectations for the nation’s physician workforce. Since the enactment of Medicare in 1965, Congress has repeatedly amended the statute, including many amendments to Medicare GME policy. The following is an illustrative but by no means exhaustive list of pivotal reports, articles, and amendments, by year.

Key: + = report foresaw a physician surplus; − = report foresaw a physician shortfall; ■ = Republican; ● = Democrat; ■/● = no majority party. AACOM = American Association of Colleges of Osteopathic Medicine; AMA = American Medical Association; AAHC = Association of Academic Health Centers; AAMC = Association of American Medical Colleges; NMA = National Medical Association; DHHS = Department of Health and Human Services.

<table>
<thead>
<tr>
<th>Pivotal Reports and Articles on GME</th>
<th>Year</th>
<th>Senate Majority Party</th>
<th>House Majority Party</th>
<th>Presidency Party</th>
<th>Major Amendments to GME Legislation</th>
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<tbody>
<tr>
<td>Flexner Report: Medical Education in the United States and Canada*</td>
<td>1910</td>
<td>■</td>
<td>■</td>
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<tr>
<td>1st Rappleye Report: Medical Education—Final Report of the AAMC Commission on Medical Educationb</td>
<td>1932</td>
<td>●</td>
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<tr>
<td>2nd Rappleye Report: Graduate Medical Education Report of the Commission on Graduate Medical Educationc</td>
<td>1940</td>
<td>●</td>
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<tr>
<td>Coggeshall Report: Planning for Medical Progress Through Education—A Report Submitted to the Executive Council of the AAMCe</td>
<td>1965</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>P.L. 89-97, the Social Security Amendments of 1965, added Title XVIII to the Social Security Act to establish the Medicare program.²</td>
</tr>
<tr>
<td>Report of the National Advisory Committee on Health Manpowerf</td>
<td>1967</td>
<td>●</td>
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<tr>
<td></td>
<td>1972</td>
<td>●</td>
<td>●</td>
<td>■</td>
<td>Sec. 223 of P.L. 92-603, the Social Security Amendments of 1972, the administration established the basic formulas for determining Medicare GME payment adjustments—both DGME and IME.³</td>
</tr>
<tr>
<td>Summary Report of the GME National Advisory Committee to the Secretary, DHHS, Volume II</td>
<td>1980</td>
<td>●</td>
<td>●</td>
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<td></td>
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<tr>
<td></td>
<td>1982</td>
<td>■</td>
<td>●</td>
<td>■</td>
<td>Sec. 101(c) of P.L. 97-248, the Tax Equity and Federal Responsibility Act (TEFRA), proposing legislation to establish a new inpatient prospective payment system for hospitals based on diagnosis-related group (DRG).⁴</td>
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<tr>
<td></td>
<td>1983</td>
<td>■</td>
<td>●</td>
<td>●</td>
<td>Title VI of P.L. 98-21 established the Medicare DRG-based IPPS, including DGME and IME payment adjustments.⁵</td>
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(continued)
Table 1. History of key graduate medical education (GME) reports and legislation (continued)

<table>
<thead>
<tr>
<th>Pivotal Reports and Articles on GME</th>
<th>Year</th>
<th>Senate Majority Party</th>
<th>House Majority Party</th>
<th>Presidency Party</th>
<th>Major Amendments to GME Legislation</th>
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<tr>
<td>Annual Reports of the Council of Graduate Medical Education (COGME)h</td>
<td>1990s</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>+</td>
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<tr>
<td>Forecasting the effects of health reform on U.S. physician workforce requirement: Evidence from HMO staffing patternsi</td>
<td>1994</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>+</td>
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<td>Consensus Statement on Physician Workforce, signed by AACOM, AMA, AOA, AAHC, AAMC, and NMAj</td>
<td>1997</td>
<td>■</td>
<td>■</td>
<td>●</td>
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<td>Economic and demographic trends signal an impending physician shortagek</td>
<td>1999</td>
<td>■</td>
<td>■</td>
<td>●</td>
<td>+</td>
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<tr>
<td>The Complexities of Physician Supply and Demand: Projections Through 2025l</td>
<td>2002</td>
<td>■/●</td>
<td>●</td>
<td>●</td>
<td>−</td>
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<tr>
<td>Ensuring an Effective Physician Workforce for the United States: Recommendations for GME to Meet the Needs of the Publicm</td>
<td>2010</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>−</td>
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<td>GME That Meets the Nation’s Health Needsn</td>
<td>2011</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>−</td>
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<tr>
<td>The Complexities of Physician Supply and Demand: Projections From 2013 Through 2025o</td>
<td>2014</td>
<td>●</td>
<td>●</td>
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P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, changed the weighting of the DGME formulas to favor primary care training over specialist training. It also established the “per resident amount.”

P.L. 105-33, the Balanced Budget Act of 1997, capped the number of residents for which each hospital could claim Medicare GME payment and requires GME payments for teaching hospitals that care for patients enrolled in Medicare managed care plans.

P.L. 106-113, the Balanced Budget Refinement Act of 1999, adjusted the percentage add-on factor to IME payments.

P.L. 111-48, Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010, authorized the redistribution of unused residency slots for which Medicare GME payments were not claimed and residency slots in hospitals that had ceased to operate.
Notes for Table 1

(+)= projected physician surplus; (−)= projected physician shortfall

**Pivotal Reports and Articles on GME**

a. **1910 (+)** The “Flexner” report, prepared by Abraham Flexner for the Carnegie Foundation for the Advancement of Teaching, spoke of a nationwide surplus of ill-prepared physicians but a deficit of physicians actually qualified to care for patients. “It appears the country needs fewer and better physicians, and the way to get them better is to produce fewer.” (Flexner A. Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching. Bulletin No. 4. New York, N.Y.: The Carnegie Foundation for the Advancement of Teaching, 1910: 346; OCLC 9795002.)

b. **1932 (+)** The first “Rappleye” report was the product of the Commission on Medical Education of the Association of American Medical Colleges, led by Willard Rappleye, MD. It said the country needed 120,000 physicians but had an oversupply of 25,000. (Rappleye WC. Medical Education: Final Report of the Commission on Medical Education. New York, N.Y.: Association of American Medical Colleges, 1932.)

c. **1940 (−)** The second “Rappleye” report was prepared for the AAMC by the Commission on Medical Education under the leadership of Dr. Rappleye. The commission said: “If consideration is limited to residencies of three years or more in length in these approved (teaching) hospitals, there will be need for approximately a 50 percent increase in the number of acceptable residencies.” (Commission on Graduate Medical Education. Graduate Medical Education: Report of the Commission on Graduate Medical Education. Chicago, Ill.: University of Chicago Press, 1940.)


e. **1965 (−)** The “Coggeshall” report, by Lowell T. Coggeshall, MD, foresaw a chronic shortage. “There is every indication that the future will see more health care demanded and provided than ever before. . . . (I)t is clear that more physicians must be trained and as quickly as possible. . . . (I)t is not likely America will ever be able to produce all the physicians that the nation would like to have. . . . Increasing physician productivity is probably the most important step to alleviate the growing physician ‘shortage.’ This will require delegating tasks to others.” (Coggeshall LT. Planning for Medical Progress Through Education. Evanston, Ill.: Association of American Medical Colleges, 1965.)

f. **1967 (−)** This report, by J. Irwin Miller, stated: “The Commission believes there currently is a shortage of physicians, and this shortage will worsen . . . .” (Miller JI, chair, National Advisory Commission on Health Manpower. Report of the National Advisory Commission on Health

g. 1980 (+) Volume 1 of this summary report by an advisory committee to the DHHS secretary, chaired by Alvin Tarlov, MD, projected that by 1990, the country would have 70,000 physicians more than required. (Tarlov AR, chair, Graduate Medical Education Advisory Committee. Summary Report of the Graduate Medical Education Advisory Committee to the Secretary of Health and Human Services, Volume 1. Washington, D.C.: U.S. Department of Health and Human Services, September 30, 1980.)

h. 1990s (+) Annual reports of the COGME in the federal Health Resources and Services Administration (HRSA) repeatedly spoke of a national physician workforce surplus. For example, the council’s 11th annual report (1998), International Medical Graduates, the Physician Workforce, and GME Payment Reform, said, “It has long been the position of the Council on Graduate Medical Education that the United States has too many physicians and these physicians are not appropriately distributed across medical specialties and location.” These findings were consistent with those of many others in the 1990s, including the Institute of Medicine, Pew Health Professions Commission, the AAMC, and AMA. (Council on Graduate Medical Education. Eleventh Report: International Medical Graduates, the Physician Workforce, and GME Payment Reform. Washington, D.C.: U.S. Department of Health and Human Services, March 1998.)

i. 1994 (+) This article, by Jonathan Weiner, JAMA, forecast “that in the year 2000 . . . there will be an overall surplus of about 165,000 patient care physicians . . . and the supply of specialists will outstrip the requirement by 60%.” He based his projections on evidence of reduced physician utilization in closed-panel HMOs. (Weiner JP. Forecasting the effects of health reform on U.S. physician workforce requirement: Evidence from HMO staffing patterns. JAMA 1994;272(3):222-230.)

j. 1997 (+) This statement, signed on February 28, 1997, said, “. . . (S)tudies of the physicians workforce have produced compelling evidence that the United States is on the verge of a serious oversupply of physicians . . . .” (Cohen JJ. Consensus Statement on Physician Workforce, Memorandum #97-9 to the Council of Deans, Council of Teaching Hospitals and Health Systems, Council of Academic Societies. Washington, D.C.: Association of American Medical Colleges, February 28, 1997.)

k. 2002 (−) This Health Affairs article, by Richard Cooper et al., stated: “It is widely believed that the United States is producing too many physicians. We have approached this issue by developing a new model . . . this model projects that the United States will soon have a shortage of physicians and that if the pace of medical education remains unchanged, the shortage will become more severe.” (Cooper RA, Getzen TE, McKee HJ, Laud P. Economic and demographic trends signal an impending physician shortage. Health Aff 2002;21(1):140-54.)


m. 2011 (−) This report is about a May 2011 conference sponsored by the Josiah Macy Jr. Foundation. It said, “Predictions of physician workforce needs have a poor track record for accuracy. However, the current demographics of our general population and the physician
workforce make a shortage of physicians in the near future very likely . . . many predict it will be in excess of 100,000 physicians by the middle of the next decade.” The report is one of several the foundation has produced over decades that champion major changes in the organization and implementation of UME and GME. (Weinstein D. Ensuring an Effective Physician Workforce for the United States: Recommendations for Graduate Medical Education to Meet the Needs of the Public. Proceedings of a conference sponsored by the Josiah Macy Jr. Foundation, Atlanta, GA, May 16-19. New York, N.Y.: Josiah Macy Jr. Foundation, 2011.)

n. 2014 (+) Don Berwick et al. wrote this report for the National Academies’ Institute of Medicine (IOM) Committee on the Governance and Financing of Graduate Medical Education. In dismissing the recommendations of those who call for increased federal Medicare support for residency training in order to avoid a projected workforce shortfall, the report cited the unreliability of past shortfall projections and said, “Simply increasing the numbers 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. The evidence instead suggests that, although the capacity of the GME system has grown in recent years, it is not producing an increasing proportion of physicians who choose to practice primary care, to provide care to underserved populations, or to locate in rural or other underserved areas.” (Eden J, Berwick D, Wilensky G, eds. Institute of Medicine Committee on the Governance and Financing of Graduate Medical Education. Graduate Medical Education That Meets the Nation's Health Needs. Washington, D.C.: National Academies Press, 2014.)

o. 2015 (−) Commissioned by the AAMC, this February 2015 report, by Tim Dall et al., IHS Inc., uses a microsimulation forecasting model and examines the potential impact of several different scenarios on future physician workforce supply and demand. The report concludes that by 2025, demand would exceed supply in all scenarios, with a total shortage of all physicians projected to range from 46,000 to 91,000. (IHS Inc. The Complexities of Physician Supply and Demand: Projections from 2013 Through 2025. Washington, D.C.: Association of American Medical Colleges, 2015.)

Significant Legislative Milestones in the History of Medicare GME Policy

p. P.L. 89-97 added Title XVIII to the Social Security Act to establish the Medicare program, including cost-based reimbursement for hospitals.

q. Sec. 223 of P.L. 92-603 gave the Executive Branch the authority to take the first steps toward prospective payment that would give incentives to providers to control their costs. In using this authority to limit Medicare reimbursement, the administration established the basic formulas for determining Medicare GME payment adjustments for both DGME and IME.

r. Sec. 101(c) of P.L. 97-248 directed the Department of Health and Human Services (DHHS) Secretary—consulting with congressional committees of jurisdiction—to submit a report proposing legislation to establish a new inpatient prospective payment system for hospitals based on the diagnosis-related group (DRG) (DRG-based IPPS).

s. Title VI of P.L. 98-21, the Social Security Amendments of 1983, established the Medicare DRG-based IPPS, including DGME and IME payment adjustments as recommended by DHHS in 1982.
t. **P.L. 99-272** changed the weighting of the DGME formulas to favor primary care training over specialist training. It also established the “per resident amount.”

u. **P.L. 105-33** capped the number of resident FTEs for which a hospital could qualify for Medicare GME reimbursement at the number the hospital had at the end of 1996, and it required GME payments for teaching hospitals that care for patients enrolled in Medicare managed care plans.

v. **P.L. 106-113** adjusted the percentage add-on factor to IME payments, one of many adjustments to the add-on factor made over many years.

w. **P.L. 111-48** authorized the redistribution of unused residency slots for which Medicare GME payments were not claimed and residency slots in hospitals that had ceased to operate.

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