Reforming the Financing and Governance of GME

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Several recent reports have highlighted the mismatch between the health needs of the U.S. population and the specialty distribution of newly trained physicians, the continuing geographic maldistribution of physicians within the country, inadequate diversity among physicians, gaps in physicians' skills for practicing in the new health care delivery context, and the lack of fiscal transparency in the graduate medical education (GME) system. As a direct follow-on to two Macy Foundation reports on these issues,[1,2] the Institute of Medicine (IOM) convened a Committee on the Governance and Financing of GME. That committee, which we cochaired, issued its own report on July 29.[3]

The charge to the IOM committee was to review the financing and governance of GME and to make recommendations for improving it. The committee's overarching task was to assess the extent to which the current GME system is helping to produce a physician workforce that is ready to provide high-quality, patient-centered, affordable health care. The committee recognizes that GME by itself cannot produce a high-value health care system, but the committee believes that GME can have a substantial influence on the development of the physician workforce that such a system needs.

The committee agreed to a set of six goals for the future configuration of GME financing and governance. These include the production of a physician workforce that is better prepared to work in a delivery system that provides better patient care, improves population health, and does so at lower cost — what has been articulated as the "triple aim"[4]; innovations in the structure, location, and design of GME to achieve that desired physician workforce; greater transparency and accountability for achieving GME goals; more efficient use of public funds; greater clarity in the planning and oversight of GME policy; and mitigation of unwanted consequences of migration to a new GME system.

After reviewing the relevant literature, the committee reached several important conclusions that helped shape its recommendations: forecasts of future physician shortages are variable and have been historically unreliable; increasing the number of physicians is unlikely to resolve specialty and geographic maldistribution; increasing Medicare funding is not essential for increasing the physician workforce — the number of U.S. residency positions has increased by 17.5% in the past decade, despite a cap on the number of Medicare-funded slots; current programs are producing an increasingly specialized workforce that is insufficiently responsive to local and national needs; and many newly trained physicians lack essential office-based skills.

The committee debated at great length whether it is justifiable to continue government funding for GME, through either Medicare or other sources; current government funding is an estimated $15 billion per year. It noted the lack of similar funding for undergraduate medical education and for other health care professions and nonmedical professions that are also important to society and whose workforce may also fall short of demand.

Three considerations ultimately led to the recommendation that Medicare GME funding (updated for inflation) should continue for at least the next 10 years, assuming that the types of reforms reflected in our other recommendations are undertaken. The first consideration was that the delivery system is in the midst of considerable change, as it moves toward a health care system focused on improving the patient's health care experience, lowering costs, and improving population health. Second, continued Medicare funding can be used to leverage the changes that are needed to produce a physician workforce that is better suited to such a reformed delivery system. And third, funding from Medicare, because it is an entitlement program, can provide a level of stability and predictability that other funding sources cannot provide and that is critical for transforming the GME program, which by its nature requires multiyear commitments.

The committee proposes, however, that GME funds be distributed in two streams: an operational fund whose role is to support continued funding for current GME programs, and a transformation fund intended to support innovation in the patterns and use of GME funding. Among other uses, a transforma-

tion fund would support the development of performance-based GME metrics — a key requirement if the goals of greater transparency and accountability are to be met. The relative amounts allocated to these two funds should shift over time, as GME sponsoring groups and other institutions develop the capacity to make good use of the transformation fund and as some of the results of innovations reach the point where they are ready to be incorporated into the programs supported by the operational fund.

These funding changes are part of the five major recommendations the committee has made. First, Medicare should maintain its GME support (the total of its direct and indirect medical education funds), adjusted for inflation, while gradually moving to a performance-based system with oversight and accountability that encourages innovation. The current GME payment system should be replaced in phases by a new one.

Second, an adequately resourced GME policy council should be created in the Office of the Secretary of Health and Human Services to develop a strategic plan for GME funding, sponsor research regarding the sufficiency of a future physician workforce, and coordinate collaborative activities among federal agencies and accrediting and certifying organizations. A GME Center should also be established within the Centers for Medicare and Medicaid Services to manage and distribute the funds in a manner consistent with the policies developed by the policy council.

An audio interview with Dr. Wilensky is available at NEJM.org

Third, a single Medicare GME fund should be created with two component funds: the GME Operational Fund to distribute ongoing support for residency training positions that are currently approved and funded and a GME Transformation Fund to finance initiatives to develop and evaluate innovative GME programs, determine and evaluate GME performance measures, pilot new GME payment methods and programs, and award new Medicare-funded GME training positions in priority specialty and geographic areas.

Fourth, the Medicare payment methods should be simplified by replacing the current direct and indirect GME funding with a single payment to organizations sponsoring GME programs that is based on a national, geographically adjusted, per-resident amount. The per-resident amount should be set by dividing the total value of the GME Operational Fund by the current number of full-time Medicare-funded training slots and should be distributed directly to GME sponsoring institutions. Performance-based payments should be implemented over time on the basis of lessons from the Transformation Fund pilot projects.

And fifth, Medicaid funding for GME should remain at the discretion of individual states. However, Congress should require the same level of accountability and transparency in the use of Medicaid funds as is being proposed for Medicare-funded GME programs.

The committee recognizes that the redesigning and repurposing of Medicare funds will be disruptive for the teaching hospitals and other GME sponsors that have been receiving GME funding in approximately the same way for more than 30 years. For that reason, the committee recommends a phased implementation over a 10-year period. An additional assessment regarding the ongoing need for Medicare funding should be conducted at that time. Despite the potential for disruption, the committee firmly believes that Medicare funding of GME can and should be better leveraged than it has been to date for achieving national health care objectives and meeting the needs of the American people. Only then can the use of continued public funding of GME be justified.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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