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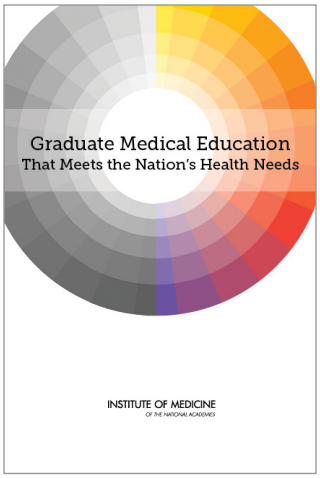
Graduate Medical Education That Meets the Nation's Health Needs



Since the creation of the Medicare and Medicaid programs in 1965, the public has provided tens of billions of dollars to fund graduate medical education (GME), the period of residency and fellowship that is provided to physicians after they receive a medical degree. Although the scale of government support for physician training far exceeds that for any other profession, there is a striking absence of transparency and accountability in the GME financing system for producing the types of physicians that the nation needs.

In 2012, the Josiah Macy Jr. Foundation asked the Institute of Medicine (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). Eleven U.S. senators, from both sides of the aisle, encouraged the IOM to undertake the study.

The 21-member IOM committee concludes that there is an unquestionable imperative to assess and optimize the effectiveness of the public's investment in GME. In its report, *Graduate Medical Education That Meets the Nation's Health Needs*, the committee recommends significant changes to GME financing and governance to address current deficiencies and better shape the physician workforce for the future.

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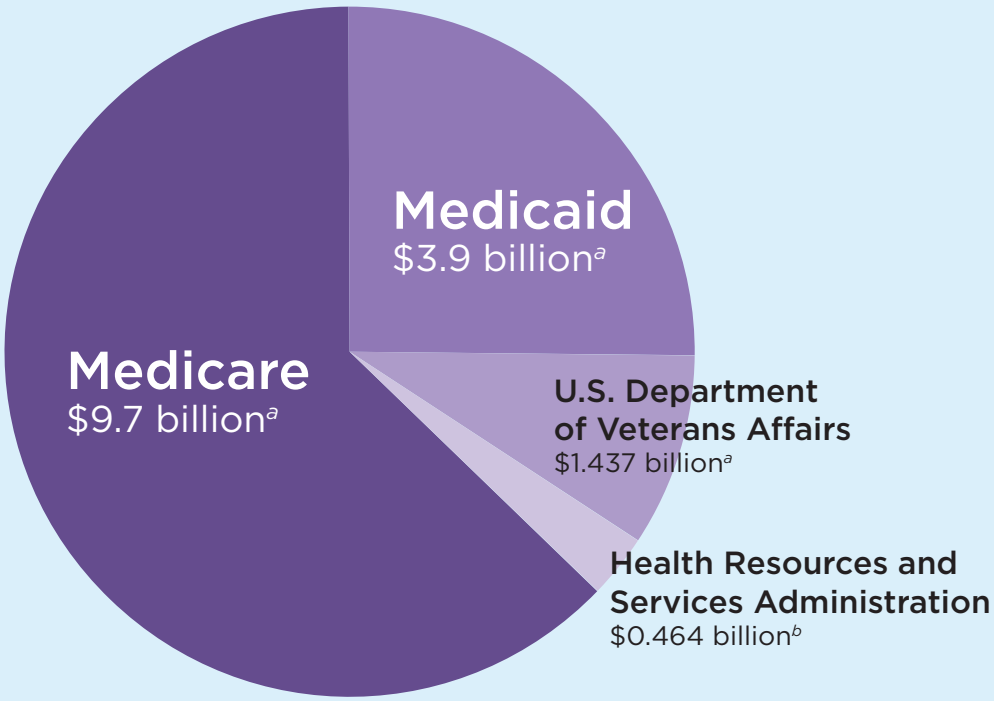
The Role of Medicare

The vast 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. Indeed, Medicare has provided a secure and stable funding source for residency training for almost 50 years. During that time, residency positions have expanded in number and in the breadth of specialties; residents' working conditions have improved; substantially more women are in the training pool; the number of underrepresented minorities has increased (although greater representation is still needed); and residency training has evolved from an apprenticeship model emphasizing service to a curriculum-based educational experience tied to the achievement of defined competencies.

However, the statutes and regulations governing GME financing date from 1965, a time when hospitals were the central, if not exclusive, site for physician training. Medicare GME payment rules continue to reflect that era despite dramatic changes in the health care system. Although hospital services remain essential, the burden of chronic disease, the need for greater emphasis on preventive care, and modern information technologies (as well as other influences) mean that health care increasingly takes place in community settings and relies on nonphysicians and integrated care models. Yet, the Medicare GME payment system discourages physician training outside the hospital, where most health care is delivered.

Although Medicare's dominant role in GME funding could be viewed as an historical accident, the IOM committee finds that there is great potential to leverage Medicare's investment in GME by redesigning the system to reward desired outcomes and program performance. Despite the system's flaws, to withdraw Medicare funding altogether would risk serious unintended consequences. Instead, the committee calls for reforms

FIGURE: Estimated sources of $15 billion in public funding for GME



NOTE: Additional unreported funding comes from the Department of Defense, state sources, private insurers, and other private sources. *a* = data from 2012; *b* = data from 2011 and 2013.

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to the way Medicare's GME funds are allocated and increased oversight and accountability for the GME system as a whole.

Although additional public GME funding comes from Medicaid, VA, HRSA, the Department of Defense, and state sources (see Figure), the committee's recommendations focus on Medicare as the largest and most influential contributor—and therefore the contributor with the most potential to effect change.

Goals for Improved GME Financing

The IOM committee identifies six goals for an improved GME financing system. These goals guided the committee's assessment of current GME funding and shaped its recommendations for reform.

1. Encourage production of a physician workforce better prepared to work in, help lead, and continually improve an evolving health care delivery system that can provide better individual care, better population health, and lower cost.
2. Encourage innovation in the structures, locations, and designs of GME programs to better achieve Goal 1.
3. Provide transparency and accountability of GME programs, with respect to the stewardship of public funding and the achievement of GME goals.
4. 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.
5. Ensure rational, efficient, and effective use of public funds for GME in order to maximize the value of this public investment.
6. Mitigate unwanted and unintended negative effects of planned transitions in GME funding methods.

Recommendations

Significant reforms are needed to ensure value in the public's sizable investment in physician education. Because the rules governing Medicare GME financing are rooted in statute, they cannot be revised without legislative action. As such, the IOM committee strongly urges Congress to amend Medicare law and regulation to allow a transition to an accountable, performance-based system.

Transforming Medicare's role in financing GME will be a complex undertaking and requires careful planning. The committee recommends a 10-year transition from the status quo to full implementation of its recommendations, followed by a reassessment of the need for continued Medicare GME funding. Every effort should be made to mitigate negative effects for the institutions involved. Specifically, the committee recommends:

- **Investing strategically:** Maintain Medicare GME funding at its current level, but modernize payment methods to reward performance, ensure accountability, and incentivize innovation in the content and financ-

ing of GME. The current Medicare GME payment system should be phased out.

- **Building an infrastructure to facilitate strategic investment:** Establish a two-part governance infrastructure for federal GME financing. A GME Policy Council in the Office of the Secretary of the Department of Health and Human Services should oversee policy development and decision making. A GME Center within the Centers for Medicare & Medicaid Services should function as an operations center with the capacity to administer payment reforms and manage demonstrations of new payment models.
- **Establishing a two-part Medicare GME fund:** Allocate Medicare GME funds to two distinct subsidiary funds—a GME Operational Fund to finance ongoing residency training activities and a Transformation Fund to finance development of new programs, infrastructure, performance methods, payment demonstrations, and other priorities identified by the GME Policy Council.

Conclusion

The IOM committee began its deliberations with a basic question: Should the public continue to support GME, and, if so, at what level? Ultimately, the committee concludes that continued Medicare support is warranted—at least for the next decade—assuming that current deficiencies are resolved. The IOM report provides an initial roadmap for reforming the Medicare GME payment system and building an infrastructure that can drive more strategic investment in the nation's physician workforce.

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