IOM REPORT: GME THAT MEETS THE NATION'S HEALTH NEEDS
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RECOMMENDATIONS FOR REFORMING GME GOVERNANCE AND FINANCING

The committee strongly urges Congress to amend Medicare law; these recommended reforms cannot occur without legislative action. The committee recommends a 10-year transition from the status quo to full implementation of the recommendations

Recommendation 1: Maintain Medicare GME support at the current aggregate amount while taking steps to modernize GME payment methods based on performance, to ensure program oversight and accountability, and to incentivize innovation in the content and financing of GME. The current Medicare GME payments system should be phased out.

Recommendation 2: Build a GME policy and financing infrastructure.

- 2a. Create a GME Policy Council for: Development and oversight of a strategic plan for Medicare GME financing; Research and policy development regarding the sufficiency, geographic distribution, and specialty configuration of the physician workforce
- 2b. Establish a GME Center within CMS that is responsive to the ongoing guidance of the GME Council: Management of the operational aspects of GME funding; Data collection and detailed reporting to ensure transparency in the distribution and use of Medicare GME funds

Recommendation 3: Create one Medicare GME fund with two subsidiary funds:

- 3a. A GME Operational Fund to distribute ongoing support for residency training positions that are currently approved and funded
- 3b. A GME Transformational Fund to finance initiatives to develop and evaluate innovative GME programs.

Recommendation 4: Modernize Medicare GME payment methodology: Replace the separate IME and DME with one payment to organizations sponsoring GME programs, based on a national per-resident amount (with a geographic adjustment); Redirect the funding stream so that GME operational funds are distributed directly to GME sponsoring organizations

Recommendation 5: Medicaid GME funding should remain at the state's discretion. However, Congress should mandate the same level of transparency and accountability in Medicaid GME as it will require under the changes in Medicare GME herein proposed.

REPORT BACKGROUND AND RATIONALE

Overview

- In 2012, more than $13B was spent to support residency training ($9.7B Medicare, $3.9B Medicaid)
- Need for improvements in GME system; in the past, a range of concerns have been raised related to mismatch between the health needs of the population and the specialty make-up of the physician workforce, persistent geographic maldistribution of physicians, insufficient diversity in physician populations, a gap between physician training and competencies required for current medical practice, and a lack of fiscal transparency and accountability.
- Overarching question in this report: To what extent is the current GME system producing an appropriately balanced physician workforce to provide high-quality, patient-centered, and affordable health care?
- Committee concluded GME needs secure and predictable funding; achievable by keeping federal GME support in Medicare; should avoid a federal program that is subject to annual discretionary funding
- The outcomes of the *current* GME governance and financing system:
    - Physician Workforce: increasing physician production alone is unlikely to resolve workforce shortages where shortages are most acute, and unlikely to ensure sufficient distribution and number of providers in all specialties and care settings; some evidence shows that that newly trained physicians in some specialties have difficulty performing simple office-based procedures and managing routine conditions

- Unintended consequences of Medicare GME payment methods: The Medicare GME system is complex and opaque and discourages physician training outside the hospital, in clinical settings where most health care is delivered
- Stewardship of public funding: Because Medicare GME funding is formula-driven, the payments are essentially guaranteed (to teaching hospitals) regardless of whether the funded trainees reflect local, national, or regional health needs

1. Introduction

- IOM definition of primary care: "The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." In context of GME, primary care refers to medical specialties, including family medicine, general internal medicine, and general pediatrics. Sometimes OB/GYN, psychiatry, and geriatrics are also considered to be primary care specialties.

2. Background on the Pipeline to the Physician Workforce

- Physician Supply: forecasts are variable, contradictory, based on problematic methodology and assumptions
  - Pushing for significant increases in Medicare GME funding to increase the overall numbers of physicians is not justified at this time and is unlikely to resolve workforce shortages in regions of the country where shortages are most acute, and also unlikely to ensure a sufficient number of providers in all specialties and care settings.
- The GME Pipeline: Medical School Enrollment: In past decade, has been a marked increase in number of medical schools and size of med school classes
- GME Training Capacity: Trends in number and type of GME programs
  - Number of residency programs and residents have steadily increased in last decade (16% and 17.5% respectively)
  - There has been increasing sub-specialization in GME (in the early 1960s, PCPs made up an estimated half of the physician workforce; in 2010, it was roughly 33%)
  - Influences on Specialty Career Choice: future incomes, production of specialists and sub-specialists evolved without strategic direction or planning
  - Primary care workforce: comprised of physicians (74%), NPs (19%), and PAs (7%)
- Readiness to Practice: Observations indicate that new physicians often lack sufficient training and experience in care coordination, team-based practice, costs of care, cultural competence, and quality improvement, which may be a result of the nature of sites where physicians are trained (hospitals primarily, although the Teaching Health Center program is a step towards expanding training in community settings)
- Diversity of Physician Trainee Pool: progress has been made, but with growing diversity of overall US population, racial and ethnic differences between med school grads and overall population is widening
- Geographic Maldistribution: physicians live and practice primarily in suburban and metro areas, with a disparity between where the US population lives and how many physicians practice in those areas, and there is a decline in med students with rural backgrounds
  - The location of GME training is predictive of practice location, and the longer the period of training in a particular geographic area, the more likely the individual is to practice there, and the output of the GME pipeline is trending towards greater specialization with no evidence of expanding training capacity in areas where it is most needed
  - "There is a clear and compelling imperative for the nation to leverage its investment in GME toward producing a physician workforce ready to provide high-quality, patient-centered, and affordable health care in all regions of the nation."

3. GME Financing

- Medicare GME is complex and largely undocumented; not well understood
- GME funds are distributed primarily to teaching hospitals which have control over the funds; this creates a disincentive to training in non-hospital settings where most residents will eventually practice and most people seek health care services
- Institutions with multiple residency programs sponsor the vast majority of residency programs (96%); community hospitals and ambulatory care settings sponsor less than 1% of residency programs
- Medicare GME formulas are linked to Medicare patient volume, so the system disadvantages children's hospitals, safety net hospitals, and other training sites that care for mostly non-elderly patients

- Training slots are frozen where they existed over a decade ago, perpetuating inequities in the geographic distribution of training slots and ignoring changes in the geography and demography of the US population
- Medicare GME funding is formula-driven without accountability for national health care needs or priorities
- The current GME financing system offers little, if any, incentives to improve the quality or efficiency of physician training

4. Governance

- There is no overarching system that oversees public GME funding in the interest of the nation's health or health care workforce needs; the financing and governance of the GME system are essentially disconnected
- Federal GME funding is guaranteed, with requirement that programs be accredited to receive federal support
- Under the status quo, program outcomes are neither measured nor reported
- Many of the fundamental questions about the effectiveness of the GME funding system are unanswerable
- The Medicare GME programs should have: transparency, simple and logical infrastructure for oversight and strategic policy development and implementation, methods tied to goals to meet the needs of the public, performance measures for accountability, and transparency to report to the public and other stakeholders

5. Recommendations for the Reform of GME Financing and Governance

Below are the goals the study committee identified as they prepared to develop GME policy recommendations:

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
    a. GME financing does not encourage the production of the physician workforce that the nation needs. Under current statute, Medicare funds residents regardless of local, regional, or national workforce needs or the quality of the training programs.
2. Encourage innovation in the structures, locations, and designs of GME programs to better achieve Goal #1
    a. Funds should be distributed to the organizations that sponsor residency programs, not just the teaching hospitals that employ or otherwise rely on residents' services. Under the status quo, nearly all GME training occurs in hospitals – including primary care residencies – even though non-hospital settings are where most physicians will spend their careers and where most people seek health care services.
    b. GME payments should reward performance and reflect local, regional, and national workforce needs. This will require the introduction of performance-based payment methods.
    c. The linkage between hospital Medicare patient volume and GME payment should be phased out.
    d. The separate DME and IME funding streams should be merged into a uniform per resident amount (PRA)
3. Provide transparency and accountability of GME programs, with respect to the stewardship of public funding and the achievement of goals for the investment of those funds
    a. Fundamental questions about GME financing and program outcomes cannot be answered
    b. Medicaid GME has no reporting requirements
    c. Even Medicare program staff within teaching institutions has limited information regarding the net financial impact of GM
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
    a. The Medicare GME program should have a transparent, simple, and logical organizational infrastructure
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
    a. The committee acknowledges that redesigning Medicare GME funding will be disruptive for teaching hospitals and other sponsors of residency programs.
    b. A well-planned, long-term period of transition is of paramount importance.