INSTITUTE OF MEDICINE’S REPORT:  
GRADUATE MEDICAL EDUCATION THAT MEETS THE NATION’S HEALTH NEEDS

EXECUTIVE SUMMARY
Last week, the Institute of Medicine (IOM) published a long-awaited report on graduate medical education (GME) that calls for transitioning the current GME system to a transparent, performance-based system over the next ten years. The report provides extensive background information (facts, data, statistics) relating to the current state of graduate medical education, simultaneously identifying six goals to improving the future of GME. The IOM Committee on the Governance and Financing of Graduate Medical Education developed five recommendations that will significantly reform GME financing and government.

Significant modifications:
1. Combining IME and DGME – however, dividing Medicare funding into two separate subsidiary funds
   a. Operational Fund: to maintain funds for current/approved residency programs
   b. Transformational Fund: to finance initiatives, research, demonstration projects, etc. Additionally funding the creation of the GME Policy Council and GME Center
2. A uniform per-resident amount (PRA)
3. Performance-based metrics for GME funding purposes – The Committee is fostering this model from previous reports/publications by other federal advisory groups. The list of measureable goals provided in the report are more of a reference of expected “outcomes”
4. Transparency and accountability – According to the report, there is very limited, complete and comparable data (transparency) and Medicare funding is formula driven without accountability. The Committee recommends more transparency and increased accountability, which may be a sizable task.

Other Funding Mechanisms
The report does not address the role of other payers, including private payers, local communities, and other stakeholders but maintains Medicare as the primary source for GME funding.

Physician Shortage
The report suggests the physician shortage is based on studies with unreliable methodologies that do not adequately relate the demand for physicians to the features of a high performing system of care. The report found little evidence to indicate that current terms of GME financing encourage the production of the types of physicians required by the health care system. Therefore, the Committee feels that advocating for increased federal GME funding would be “irresponsible without evidence” that the current level of investment is helping to produce the workforce needed. Instead the report suggests a focus on how best to organize and deploy physicians through innovative approaches to health care delivery. However, the report does not offer suggestions to address this matter. Additionally, in the matter of specialty career selection, the report acknowledges an imbalance of specialties; yet, lacks identifying a solution to what works best in motivating physicians to train in specialties.

Governance
The report implies the current governance of GME financing is inadequate. Approximately 200 organizations providing physician certification in various subspecialty areas represents the foundation for governance of GME. In March 2014, ACGME and the Council on Osteopathic Postgraduate Training announced an agreement to transition to a single accreditation system for GME by 2020. The proposed unification will transition the accreditation process to a competency-based and outcomes-oriented system. Per the Committee’s recommendation, these accrediting organizations will work closely with the newly created GME Policy Center in establishing a more uniformed process.
Financing
There have been a number of legislative milestones in Medicare financing of GME since the creation of retrospective cost-based methods in 1965 to the more recent measures included in the Affordable Care Act. The report repeatedly encourages action by Congress and the Secretary of Health and Human Services in reforming the Medicare GME funding.

GOALS FOR ASSESSMENT
In order to address the reform of GME, the committee concluded that leveraging the public’s investment for greater public benefit depends on “secure and predictable funding.” The committee developed the following six goals to guide its research, analysis, and eventual recommendations for the future of GME:

- **Goal 1**: Encourage production of a physician workforce better prepared to work in, to help lead, and to continually improve an evolving health care delivery system that can provide better individual care, better population health, and lower cost.

- **Goal 2**: Encourage innovation in the structures, locations, and designs of graduate medical education programs, to better achieve Goal #1.

- **Goal 3**: Provide transparency and accountability of GME programs, with respect to the stewardship of public funds and the achievement of GME goals.

- **Goal 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.

- **Goal 5**: Ensure rational, efficient, and effective use of public funds for GME in order to maximize the value of this public investment.

- **Goal 6**: Mitigate unwanted and unintended negative effects of transition from the current GME funding system to a future one.

RECOMMENDATIONS
1. **Maintain current Medicare GME funding over the next ten years**
   - The recommendation will build realignment of the program’s incentives and a plan for documentation of outcomes.
   - Continuation and appropriate funding levels will be annually reassessed after implementation of reform.
   - While overall GME funding would not be decreased, the expenditures would be split into two separate funds (described in more detail in recommendation three). As a result, while the total Medicare GME funding should remain at the current level (in an agreed-on base year—adjusted annually for inflation) during this ten-year period, the amounts dedicated directly to reimbursing residency training would be phased out and diverted to fund research and the testing of alternative “innovative” GME funding options.

2. **Build a GME policy and financing infrastructure**
   **ACTION:** Under this recommendation, the committee urges Congress and the Secretary of Health and Human Services (HHS) for immediate action to establish a two-part governance infrastructure for federal GME financing.
**ACTION:** Congress directs the Secretary to appoint no more than 12 members to the Council with staggered 6-year terms; comprised of “non-stakeholders” with broad expertise related to physician and health professions education, workforce policy, health services research, health care financing, and consumer and patient perspectives.

- Create a multi-stakeholder GME Policy Council in the U.S. Department of Health and Human Services to provide oversight and development of a strategic plan for Medicare GME financing, research sufficiency of workforce, geographic, or specialty issues, develop future federal policies, coordination between federal agencies and private accreditation and certification organizations, and provide annual progress reports on the state of GME to Congress, the Secretary and the public.

- Create a GME Center within the Centers for Medicare & Medicaid Services to manage the operational aspects of GME funding, manage Transformation Fund, and collect and report on data to ensure transparency in the use of those funds.

3. **Create one Medicare GME fund with two subsidiary funds**
   - An **Operational Fund** to distribute funds for residency training positions that are currently approved and funded.
     - (Appendix F) Aggregate funding levels in the Operational Fund will be reduced initially to 90 percent of current GME funding levels and transition to 70 percent by Year 5. One method for reducing the operational funding to generate the funding for the Transformation Fund would be to phase in a 50 percent reduction in IME operating payments to acute care hospitals. Ultimately, performance-based funding allocations would be implemented.

   - A **Transformation Fund** to finance initiatives to develop and evaluate innovative GME programs, alternative payment methods, and award new positions in priority areas (including pediatric residents currently supported by the Children’s Hospitals Graduate Medical Education), among other opportunities.
     - Initially 10 percent of total GME funding would be allocated to the Transformation Fund, moving up to 30 percent over approximately three years, and returning to the 10 percent allocation after ten years. The Transformation Fund could be used to support new residency programs but could also be used to establish the new GME financing infrastructure, to conduct research, and other activities not directly related to residency training costs.

4. **Modernize the GME payment methodology by using one payment (combining indirect and direct GME payments) based on a national per-resident amount**
   - The committee recommends a 10-year timeline for the incremental phase-in of the new payment methodology. Additionally, in the first year, children’s hospitals and THCs should be eligible to participate in the Medicare GME program at the same national PRA. The GME Policy Council should determine whether other types of training sites (e.g., cancer, psychiatric, and long-term care hospitals) should be folded into the program at a later date (with funds from the Transformation Fund).

   - Medicare GME funds will flow to program sponsors based on their total number of Medicare-funded slots instead of to teaching hospitals based on the time residents spend at their institutions and on Medicare inpatient discharges. With fiduciary control over Medicare GME payments, program sponsors will be held accountable for desired outcomes.
Transition to a uniform single PRA payment (geographically adjusted) creates the potential for transparency, accountability, program oversight, and evaluation. It also enables a more equitable distribution of GME funds allowing for the PRA to be equivalent across institutions.

The committee recommends a value-driven, performance-based metrics for payment purposes. These measures should meet outcomes, such as: competency in care coordination; clinical competencies; increase numbers of physicians in the specialties and geographic locations where they are needed; expand training in community-based settings; increase physician practice in rural clinical settings and underserved urban areas; and racial, ethnic and socioeconomic diversity.

**ACTION:** Planning for and implementation should begin quickly, such as: replacing IME and DGME separate funding streams with a national PRA; setting a national PRA; and redirecting payments to sponsoring organizations. Implementation of a performance-based payment system is a long range goal.

**ACTION:** Eliminate current freeze on funded slots, allowing for the Council to establish criteria (i.e. specialties, geographic locations, types of training sites) that defines eligibility, both for the establishment of new slots and for continued funding of existing slots.

5. **Ensure the same level of transparency and accountability** in Medicaid GME funding as proposed for the Medicare program.