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LEADERSHIP PAGE

The Future of GME Funding

A Closer Look at New Institute of Medicine Recommendations

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The recent report by the Institute of Medicine (IOM) recommending dramatic changes to the financing and governance of graduate medical education (GME) funding over the next decade has spurred much discussion and debate about the potential impact on both trainees and patients (1).

For the past nearly 50 years, more than one-half of the U.S. government-sponsored GME funding has come from the Medicare program, with most of the funding going toward training positions in the hospital setting. Other government sources of GME support have included Medicaid and the Veteran's Administration. The IOM report acknowledges that the number and types of residency positions have increased in parallel with an improvements in residents' working conditions. In addition, there are more women and under-represented minorities in the training pool and there has been a shift away from an apprenticeship model to a curriculum-based educational experience. However, the report also highlights major areas where the funding model has failed to keep up with changes in the health care environment—particularly in the continued transition of care from the hospital to the outpatient setting.

The IOM report calls for a legislated amendment to Medicare that allows for a transition—phased in over 10 years—to an "accountable, performance-based system" (1). Specific recommendations include: 1) phasing out the current Medicare GME payment system; 2) developing a new system that rewards performance, ensures accountability, and provides incentives for innovation; 3) creating an infrastructure that facilitates strategic investment; and 4) establishing a 2-part Medicare GME fund that finances ongoing residency training activities (an operational fund) as well as supports "new programs, infrastructure, performance methods, payment demonstrations, and other priorities (an innovation fund)" (1).

According to the report, these recommendations will help meet GME-financed goals to: 1) develop a physician workforce "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) provide transparency and accountability of GME programs in both funding and achievement of goals; 3) clarify public policy setting and oversight of GME funding; 4) encourage innovation "in the structures, locations, and designs" of GME programs; 5) maximize the value of public investment in GME funds in a "rational, efficient, and effective" manner; and 6) mitigate "unwanted and unintended negative effects of planned transitions in GME" (1).

The American College of Cardiology (ACC) applauds the IOM for examining the need for long-term, stable, GME funding. Support for GME needs to

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change to reflect the environment that new health care graduates are facing—an environment very different from 1965, when the Medicare law was established. Additionally, it is imperative that we find new ways to encourage research and evidence-based innovations in health care delivery. The challenge, however, is in the details.

The report does not include clear recommendations to ensure there will be an adequate number of physicians to meet the workforce needs over the next 10 years. According to the Association of American Medical Colleges, a shortage of nearly 63,000 physicians is expected in the United States by 2015, and this number is predicted to increase to 130,000 physicians across all specialties by 2024 (2). In a past President's Message, Harold et al. (3) noted that "the chances of reversing this negative workforce trend to meet the country's growing health care demands are slim in the current environment, given what can be deemed as nothing less than a 'perfect storm' of converging factors—draconian cuts in support for research, impending cuts in support for graduate medical education (GME), and declines in reimbursement for clinical activities". Radically overhauling support for GME and diverting even more funding from specialty training in the midst of a projected cardiovascular (CV) workforce shortage could pose threats to the quality, high-value care of the increasing numbers of patients with CV disease most at risk who need both primary and specialty care services.

The IOM report proposes as much as a 35% cut in payments to academic teaching hospitals, which in many cases provide the full spectrum of critical patient services like Level 1 trauma, pediatric intensive care, burn care, and access to clinical trials. Teaching hospitals are also often better equipped to provide a level of quality of training and ensure that recipients of GME funding gain broad experience in patient care across a spectrum of disease states. Although there is no denying the need for greater emphasis on preventive care and outpatient management of chronic diseases, thought must be given to how best to support teaching hospitals and specialty medical graduate education to make sure that patients continue to receive responsive, high-quality, and continuous care. Reductions in funding without a clear plan forward would be disastrous, especially among disproportionate share hospitals that provide care for the most vulnerable yet also serve as vitally important training facilities for our physician workforce.

We acknowledge that the absence of transparency and accountability in the Medicare GME financing system. We also agree that a closer look at providing support for training in the outpatient setting is warranted. The IOM's recommendation and the discussion, which has followed, are overdue. We hope that further debate and discussion will rise above the parochial interests of individual specialty societies.

From its specialty perspective, the ACC also views the report as an opportunity to reinvigorate ongoing discussions around management of chronic diseases, such as heart failure, coronary artery disease, atrial fibrillation, stroke, and diabetes. Funding for multispecialty management of chronic, noncommunicable diseases should rise to the top, with recognition of the roles played by primary care physicians, endocrinologists, cardiologists, and others. The AAMC's recommendation of targeted funding for new residency positions based on population growth, regional and state-specific needs, and evolving changes in delivery systems may help in this effort.

GME funding, physician workforce challenges, and health care delivery discussions also highlight the need for a closer look at team-based care. In light of the projected workforce shortage and continued trends in population health needs, identifying how best to leverage the skills and training of cardiovascular care team members is a major priority for the College. The importance of this effort is only strengthened by the findings of the IOM report. There are also clear opportunities for specialties like cardiology to increasingly collaborate with primary care colleagues around training and multispecialty disease management.

The changing future of GME funding provides an opportunity for the cardiovascular profession, as well as the larger house of medicine, to examine current training paradigms. Looking ahead, we need to adapt our strategies to ensure we can best meet the needs of patients and society. How do we make sure that training programs allow for adequate experience in the ambulatory care setting? What does a care team look like and how do specialists and primary care physicians and advance practitioners work together to support the needs and expectations of our patients? How do we provide for enough funding to enable life-saving research? The answers to these and other questions will determine how and if we are able to optimize the systems of care delivery in a way that most benefits both patients.

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JACC VOL. 64, NO. 22, 2014
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