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EXECUTIVE SUMMARY

Reforming Graduate Medical Education to Create the Physician Workforce America Needs

21 Billion Reasons Not to Change

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A COLLABORATIVE EFFORT BETWEEN

The University of Colorado Anschutz Farley Health Policy Center: The Farley Health Policy Center develops and translates evidence to advance policies and integrate systems that improve health, equity, and well-being. With an interprofessional team of primary care and behavioral health providers, economists, and public health and policy professionals, the Farley Health Policy Center has expertise in finance and payment policy, workforce development, system transformation to integrate care, community-based prevention and wellbeing, and social policy to address disparities.

The GME Initiative (now GME/Transformation): GME Transformation (GME/T) advances the social mission of medical education by reforming GME funding, accreditation, and governance to build a sustainable physician workforce that meets the evolving needs of patients and communities.

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Background

The need for an appropriately sized, distributed, and prepared physician workforce is increasingly urgent.

More than a decade after the Institute of Medicine (IOM; now the National Academy of Medicine) called for strategic, accountable workforce planning in its 2014 seminal report entitled "Graduate Medical Education That Meets the Nation's Health Needs," many of its core recommendations remain unimplemented.[1] Since that time, primary care match rates have stagnated, physician attrition has increased, and an aging population has accelerated demand for care as baby boomers enter Medicare in record numbers.[2] Meanwhile, the physician workforce remains heavily subspecialized and geographically concentrated in urban and suburban areas, resulting in persistent access gaps, particularly in rural and underserved communities.[3] Graduate medical education (GME), the period of residency and fellowship training after medical school, heavily shapes physician workforce outcomes. In its current form, GME financing and market-driven forces continue to shape workforce production in ways that fall short of public need, perpetuating shortages and inequities in access to care.

Calls for GME reform are not new. The 2014 IOM report remains the most comprehensive summary of the structural shortcomings in GME and the policy changes required to address them. While the report catalyzed substantial discussion and stakeholder engagement, efforts to implement its recommendations at the federal and state levels have stalled, leaving the core structure of GME financing and governance largely unchanged.

Summary of Recommendations from "Graduate Medical Education That Meets the Nation's Health Needs"[4]

Modernize Medicare GME Financing

- Maintain total Medicare GME support at current spending levels adjusted for inflation.
- Phase out the existing DGME/IME payment system in favor of a performance- and outcomes-oriented method that better aligns public funds with workforce goals.
- Redirect a portion of current GME funds to demonstration projects that realign incentives toward production of a physician workforce that meets national health needs.

Build a National GME Policy and Financing Infrastructure

- Establish a new GME Policy Council within HHS to manage operational aspects of GME payments, oversee a proposed transformation fund, and strengthen data collection and transparency.
- Create a Graduate Medical Education Transformation Fund to finance new training slots, support innovation pilots, and develop performance metrics.

Increase Transparency and Accountability

- Require better reporting on how GME funds are used and what outcomes they achieve.
- Tie public investments in GME to measurable goals (e.g., workforce distribution, competency outcomes, value).

Address Structural Barriers

- Improve governance and strategic planning for national workforce needs.
- Encourage innovation in training structures, locations, and program design to produce a workforce equipped for emerging health system needs.

Phase-In and Long Transition

- Implement recommended changes via a gradual, long-term (10-year) transition period to mitigate negative impacts on sponsoring institutions and honor existing commitments to trainees.

Sponsoring Institutions (SIs) are the entities that bear ultimate accreditation responsibility for the governance, resources, and oversight of their GME programs. While the majority of teaching hospitals serve as sponsoring institutions, the two are not synonymous.

In the current system, Medicare GME payments consist of Direct GME payments (DGME; meant to cover the direct costs of training like salaries and benefits) and Indirect Medical Education payments (IME; meant to offset the higher theoretical costs of care provided by residents).

Public investment through CMS accounts for more than 15 billion dollars annually in IME, approximately double the amount allocated to DGME.[5,6] Given the magnitude of this public investment, several concerns persist regarding the size of IME payments relative to the actual costs of residency training; their limited transparency in how funds are spent; and the substantial variation in IME payments across institutions.[7] The persistent misalignment between public investment, workforce outcomes, and population health needs underscores the necessity of renewed analysis and policy action.

This study aimed to advance evidence-informed policy recommendations to support effective advocacy and legislative action to reform GME financing and governance. To do so, the study team examined the barriers to implementing the 2014 IOM recommendations by speaking with nearly 70 key informants and reviewing over 200 articles. Through iterative rounds of structured discussion, the authors sought consensus from 37 experts on the policy changes needed to enable meaningful GME reform.

Themes for GME Policy Reform

The themes below provide a vision to guide GME reform, while the ensuing policy recommendations detail critical next steps to generate meaningful change.

THEME 1 — Three foundational ingredients are needed to reform GME: Vision, oversight, and accountability.

For there to be any substantial forward movement for GME workforce reform, there must be a federal entity responsible for understanding what is needed; planning effective solutions; developing how they will be implemented, and most importantly, measuring their impact. This entity should have the ability to enact a vision, conduct central planning, elicit bottom-up information, and provide bidirectional oversight and accountability for the American public.

THEME 2 — Secure, sufficient, and sustained funding is essential for thriving GME programs.

A vision for secure, sufficient, and sustained GME funding requires equitable payment across geographies, populations, and specialties, with funding beyond initial development to support long-term GME infrastructure and maintenance.

THEME 3 — Metrics aligned with a national vision for GME are crucial.

Federal GME funding for resident physician training must be informed by metrics that capture regional workforce needs to ensure publicly funded GME produces an equitably distributed physician workforce that is sufficiently prepared to meet the needs of diverse populations.

Policy Recommendations for GME Reform

To guide GME reform efforts, the authors propose the following policy recommendations, which are intended to be specific and actionable even in the current political climate. The most fundamental reform goal should be creating a coherent and coordinated GME system that is better equipped to produce a workforce that meets the nation's health care needs with greater value for taxpayers.[8]

Policy recommendation 1: Fund the National Health Care Workforce Commission (NHWC) with a GME subcommittee.

Utilizing the framework from the ACA, the National Health Care Workforce Commission should be funded and empowered to ensure its ability to develop and implement a national health workforce vision. A GME subcommittee should be developed to provide accountability and oversight for physician workforce needs, specifically. NHWC committee members should represent a diverse range of professional, sectoral, and demographic backgrounds. It would be required to submit regular reports on key topic areas, study GME finance and training mechanisms, and consult with federal agencies. A funded and empowered NHWC would be responsible for advancing the following core goals and functions to support coordinated, evidence-based workforce planning:

- Set workforce development goals that are informed by community needs, seeking feedback from the local, state, regional, and national levels.
- Address both geographic and specialty shortages of physicians.
- Provide leadership to coordinate central planning across different health care professions to improve team-based care.
- Advance policies that address, reduce, and prevent health inequities.
- Establish a policy council to address GME-specific governance and finance questions, including reform of the DGME and IME systems in a phased and collaborative approach.
- Define a core set of GME-specific metrics using existing CMS data that would directly tie to the health workforce priorities outlined above.
- Maintain the authority to evaluate health workforce needs and the regulatory power necessary to enact policy change.

Policy recommendation 2: Establish equitable, cost-based, national per-resident payments (PRPs) that are paid directly to Sponsoring Institutions (SIs).

A single and sufficient PRP should be operationalized to replace the multiple funding streams that support the direct costs of GME training. In its current form, DGME dollars are not adequate to support the costs of residency training for the majority of teaching hospitals. Often, it is the teaching hospital with deeper pockets, by way of IME payments, that supplements the remaining direct costs of residency training. Instead, a single and sufficient PRP should replace the complex, fragmented, and illogical funding streams that currently support GME. To transition from the current funding model to a single, sufficient national PRP, the authors propose a phased approach, informed by a diverse set of stakeholders under the leadership of the NHWC.

PRPs should be distributed directly to SIs rather than teaching hospitals, reflecting their ultimate responsibility for physician training. Guidance to assist in the transition of non-hospital entities towards becoming SIs would be necessary. This approach would preserve hospital-based programs while enabling community-based and independent sponsors to operate and expand. This essential reform dampens the market incentives that currently favor expansion of high-revenue specialties over workforce-shortage fields. Successful implementation will require a phased transition, technical support for new sponsors, and federal oversight of the NHWC to ensure accountability for workforce outcomes.

Policy recommendation 3: Implement strategic payment reform for indirect medical education (IME) funds.

The NHWC should direct the GME subcommittee to develop guidelines ensuring that IME funds are used effectively. While concerns about the current structure of IME are broadly shared, this study's findings yield little consensus on specific policy solutions for IME as it is both widely contested and deeply entrenched. Any meaningful change to IME would require careful design, stakeholder engagement, and a multi-year transition.

Given the inability to track spending patterns, longstanding hospital reliance on these funds, and the political sensitivity of IME dollars, the authors argue that IME should remain a source of operational funding for teaching hospitals in the short term. However, IME should be renamed, as there is no reliable mechanism to ensure these funds are spent on GME. Instead, there should be a direct federal investment to support a single, adequately funded PRP sufficient to cover the true costs of residency training.

There are some critical caveats. First, physicians are only one of many professions in the health care ecosystem. Reform is needed across all disciplines and levels of the health care workforce. Second, projections of a "physician shortage" and calls to "lift the cap" are not sufficient for GME reform. While a real need for more physicians may exist (acknowledging the great variability in estimates by professional organizations and across specialties), lifting the cap without a vision, plan, and/or proper oversight will continue to yield more of the same, an ineffectively distributed physician workforce that does not address geographic or specialty shortages. Third, it is essential that we do not confine our thinking to the realm of what we have implemented or tried to implement before.

Conclusion

Ten years after the IOM's 2014 report outlined a clear framework for accountable, needs-based workforce planning, the absence of meaningful implementation remains a critical policy failure.

This report argues that the question is no longer whether reform is necessary but how to implement it responsibly.

Strengthening governance, clarifying accountability, and aligning public investment with public purpose are essential steps toward a GME system that is transparent, equitable, and responsive to the needs of the American public. Advancing these reforms would honor both the intent of prior national recommendations and the obligation to ensure that public funds support a physician workforce capable of meeting the needs of patients and communities across the U.S.

To read the full report, visit farleyhealthpolicycenter.org.

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