January 15, 2015

Chairman Pitts, Ranking Member Pallone and Members of the Committee-

The Society of General Internal Medicine (SGIM) welcomes the opportunity to provide the House Committee on Energy and Commerce with our recommendations for improving the efficiency, effectiveness and stability of the Medicare graduate medical education (GME) program. While we understand the challenges and complexities surrounding any major reform, SGIM wishes to underscore the urgency of this effort. Far too much is at stake.

In addition to the recommendations detailed below, I am enclosing SGIM's responses to some of the questions posed in your December 6, 2014 letter.

SGIM is an international association of over 3,500 of the world's leading academic general internists, who are dedicated to enhancing medical education, improving access to care for vulnerable populations and eliminating health care disparities. The members of the Society advance the practice of medicine through their commitment to educating the next generation of outstanding physicians; providing comprehensive, coordinated and cost-effective care to adults; and conducting cutting-edge research to improve quality of care and clinical outcomes of all patients

While we applaud the Institute of Medicine (IOM) for its work on this important issue, we believe that GME reform must be far more comprehensive. SGIM agrees with IOM's overall goals and policy recommendations for improving GME, particularly as they relate to the dearth of primary care physicians and improving the transparency and accountability of the system. However, IOM's report should not be considered the final word on this topic but as the starting point for broader collaboration among stakeholder organizations as well as Congress—and an important steppingstone to addressing other facets of GME that fall outside the scope of IOM's report.

Over the past 30 years, GME has evolved into a multi-billion dollar enterprise, supported in large part by Medicare, which provides nearly $10 billion of the $15 billion the federal government spends annually on preparing new physicians to become high quality clinicians. Yet the GME funding structure has remained virtually static, while the current system fails to provide the physician workforce required to meet the national medical needs of the 21st century and lacks transparency and accountability.

Facing the dual challenges of an aging population and millions of people newly enrolled for health insurance coverage, SGIM in 2012 undertook a thorough assessment of GME, with a view towards better aligning that system with society's needs, resulting in recommendations for the redesign of health care workforce education and training to maximize access to and delivery of services.

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Early on, our panel of experts concluded that the current GME system is not well-aligned with the nation's health care needs, missing the mark on several fronts. Most importantly, GME is falling far short of restoring a robust, sustainable primary care workforce—the cornerstone of any high-performing health care delivery system—when the gap between generalist supply and demand will likely widen considerably.

In a landmark report, *Addressing the Nation's Physician Workforce Needs: The Society of General Internal Medicine (SGIM) Recommendations on Graduate Medical Education Reform* [include link], published earlier this year, a panel of SGIM experts set out six recommendations which reflect the concerns of an organization whose core interests include preparing a physician workforce capable of providing high-quality, high-value, population-based and patient-centered health care that is aligned with the changing needs of our nation's healthcare delivery system. Those recommendations are:

1. All entities that pay for medical care should contribute to GME funding, and funding levels should reflect the true cost of training a physician workforce aligned with national needs. Since all who receive and pay for medical care share the benefits of a well-trained physician workforce, all payers—not only CMS—should contribute to the cost of medical training. Furthermore, the decades old formula for calculating direct and indirect medical education payments is long overdue for reassessment to bring it in line with the real costs of training physicians.

2. GME dollars must be allocated transparently and exclusively for resident training and related costs. The HHS Secretary should immediately take steps to require institutions receiving GME funds to report their GME costs and the total amount of direct and indirect funds received, including the number of residents and fellows supported with GME funds by specialty and training location.

3. GME-funded training programs must demonstrate that their graduates have the competencies required to provide optimal, cost-effective care, including training in evidence-based medicine, team-based care and care coordination.

4. The GME system should provide incentives to align the practice patterns of graduates with national and regional workforce needs. Healthcare systems built upon a robust primary care workforce produce better outcomes at lower costs than systems without a primary care base. Direct accountability by GME institutions—linking the receipt of GME dollars with workforce outcomes—would be an important step to restoring a robust and sustained primary care base. To do that requires an incentive system that rewards institutions which demonstrate a sustained ability to train doctors who become primary care physicians.

5. Funding should be available to foster innovation. Over the past several decades, the capacity of medical thought and medical practice have changed profoundly, as have the demographics of disease. To remain apace, the federal government should support and test innovative education and training models that allow GME to more readily adapt to practice

in the 21st century. One recommended approach would be the creation of a Center for Medical Training Innovation, the goals of which would be to use evidence to design and test innovative training programs intended to meet the changing healthcare needs of the nation.

6. Congress should fully fund the National Health Care Workforce Commission. Decisions affecting the allocation of GME positions must be based on data from unbiased sources that assess current and accurately predict future healthcare needs. However, there currently is no overall assessment of the specialty or geographic distribution of the US physician workforce. This non-partisan Commission should develop recommendations for healthcare workforce policy, including data collection and analysis to assess current and projected workforce supply.

While it is tempting to argue that more GME funding is the answer, more money alone would not overcome the maldistribution of physicians by geography or specialty; would not sufficiently prepare graduates to provide cost-effective, evidence-based care; and would not provide them with meaningful experience in patient safety, quality improvement, chronic disease management, care of the elderly and coordination of complex care in inter-professional teams.

Aligning GME with the nation's healthcare needs will not be an easy task. It will require broad changes at multiple levels, spread over several years.

In summary, SGIM strongly urges Congress to establish a GME payment structure that adequately supports primary care, is transparent, holds teaching institutions accountable for their training outcomes and results in a workforce appropriately trained and distributed to meet the nation's health care needs.

We stand ready to work with Congress, and will continue to engage policymakers, teachers of medicine, patients and colleagues in an effort to strengthen our system of graduate medical education. Too much is at stake to delay meaningful reform of GME.

Sincerely,

William P. Moran, MD, MS

Enclosure

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Enclosure

1. *What changes to the current GME financing system might be leveraged to improve its efficiency, effectiveness, and stability?*

SGIM response: Direct medical education (DME) costs should be rebased to reflect contemporary costs of running training programs. The indirect medical education (IME) multiplier should be reconsidered to reflect actual marginal costs of being a teaching hospital.

3. *Should federal funding for GME programs ensure training opportunities are available in both rural and urban areas? If so, what sorts of reforms are needed?*

SGIM response: It is unclear whether Federal funding alone will drive the creation of training programs in rural areas. However, there may be a role for extra support of existing training programs in rural areas to ensure that these programs remain open if there is concern they may close. More study is needed to determine if training non-primary care specialists in rural areas leads to them practicing in those areas.

4. *Is the current financing structure for GME appropriate to meet current and future healthcare workforce needs?*
   i. Should it account for direct and indirect costs as separate payments?

   b. If so, are there improvements to the current formulas or structure that would increase the availability of additional training slots and be responsive to current and future workforce needs?

   SGIM response: Separate payment streams should be continued. However, primary care training programs should receive higher DME payments, and each resident should be weighted more than 1 in the resident-to-bed ratio.

   ii. Does the financing structure impact the availability of specialty and primary care designations currently? Should it moving forward?

   SGIM response: Yes, the current financing structure rewards training physicians who are in non-primary care specialty programs as they are more useful to the hospital while hospitals receive very similar amounts of IME and DME payments for them as for physicians in primary care training programs.

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