

EDUCATORS' CORNER

GME in the Crosshairs

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Earlier this year, Society of General Internal Medicine (SGIM) President William P. Moran, MD, MS, sent the leadership of the House Energy and Commerce Health Subcommittee a series of recommendations for reforming Medicare's graduate medical education (GME) program. Those recommendations were in response to the panel's call for input on how best to improve the efficiency, effectiveness, and stability of the program—and just the latest sign that changes may be afoot for the \$10-billion-a-year program.

That GME is on the minds of policymakers is neither new nor surprising. Though it may be regarded as the gold standard for the world, from the time it was established in 1965 there have been calls to change this integral part of the physician training continuum. In the 1960s, concerns were voiced that the residency programs being subsidized operated too independently of one another. By the 1970s and 80s, policymakers were bemoaning the maldistribution of physicians by specialty type and geography, laying that problem squarely on GME's doorstep. In recent years, concerns surrounding medical errors, the integration of electronic health records, and coordination of care have prompted calls for a GME makeover because, according to the Medicare Payment Advisory Commission's 2009 report to Congress, the program is "not well aligned with objectives of delivery system reform."

While Medicare's GME program has perpetually carried a target on its back, the financial crisis of 2007 truly put the program in the crosshairs of the austerity movement.

In February 2010, President Obama issued an executive order creating the bipartisan National Commission on Fiscal Responsibility and Reform, a blue-ribbon panel charged with identifying ways to right the nation's fiscal ship. What emerged was a series of bold reform proposals, many of which targeted big-ticket mandatory spending programs that collectively account for about two thirds of the federal budget. Prominent on the list, not surprisingly, was a proposal calling for a \$60 billion cut in Medicare GME payments over a decade.

Lacking the political will to take on politically charged mandatory programs like Medicare, the president and Congress instead struck a budget deal that put stringent limits on discretionary government spending. But it didn't take long before lawmakers realized that you can't get blood from a stone. Cutting discretionary spending, which accounts for a relatively small share of government spending, is simply not going to throw off enough savings to truly achieve fiscal stability. Instead, lawmakers have more recently begun to look seriously at other segments of the budget—most notably the governance and financing of GME.

Anticipating that Congress might opt for a meat-axe approach to GME reform—cutting funding while ignoring meaningful reform—SGIM undertook an in-depth examination of the system. What emerged were six recommendations that reflect the concerns of a society 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 health care delivery system. Those recommendations are:

1. *Congress should fully fund the National Health Care Workforce Commission or similar entity. Decisions affecting the allocation of GME positions must be based on data from unbiased sources that assess current and future health care needs. However, there currently is no overall assessment of the specialty or geographic distribution of the US physician workforce. The non-partisan Commission is charged with developing recommendations for health care workforce policy, including data collection and analysis to assess current and projected workforce supply.*
2. *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 just the Centers for Medicare and Medicaid Services—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.*
3. *In an era of scarce resources, GME dollars must be allocated transparently and exclusively for resident training and related*

continued on page 2

EDUCATORS' CORNER

continued from page 1

costs. The Health and Human Services 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.

4. *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.*
5. *The GME system should provide incentives to align the practice patterns of graduates with national and regional workforce*

needs. Health care 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 that demonstrate a sustained ability to train individuals who become primary care physicians.

6. *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 approach would be the creation of a Center for Medical Training Innovation, the goal of which would be to use evidence to design and test innovative training programs intended to meet the changing health care needs of the nation.

Aligning GME with the nation's health care needs will not be an easy task, but if the president and Congress are serious, meaningful GME reform should be on their to-do list.

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