

Modernizing Graduate Medical Education to Produce a Healthy America

RECOMMENDATION:

Congress should revise the way Graduate Medical Education (GME) payments are made to support production of a robust primary care workforce. Over time the U.S. should have a physician workforce that is at least 45 percent primary care and well trained to meet the needs of current and future patients. To accomplish this, Congress should:

- Support primary care training in all sites where care is delivered
- Structure GME payments for primary care residencies as the entity in charge of the education, not the hospital
- Increase payments for primary care training to support added costs of training in non-hospital settings, as well as to offer incentives to medical students who choose a primary care career
- Provide incentives for training in underserved areas
- Reward hospitals on the basis of the number of primary care physicians produced

Meeting the Primary Care Need

The current lack of a sufficiently strong primary care physician workforce has hurt our country and our patients. It has led to increased costs and lower health outcomes. Both numbers and proportion of primary care physicians need to be substantially increased. The training system is a key area that has a profound impact on the development of a primary care workforce. Currently, Medicare graduate medical education does not foster the production of high quality and high numbers of primary care physicians – in fact, it hinders those twin goals. GME had its genesis in Medicare for the purpose of helping ensure a sufficient workforce to care for the Medicare population. GME must now ensure a workforce to meet the needs of the population at large. Consequently, not only should the training system be modernized but funding GME training should also be recognized to be the responsibility of all payers, not just Medicare and Medicaid.

Steps to Modernization

Changing the funding stream, emphasizing training consistent with contemporary practice, and enhancing accountability for the product are all key steps toward modernization of the GME training system. Currently, the GME payment is hospital-oriented. As such, it reflects the inpatient hospital model of care and does not substantively compensate for the costs of training in nonhospital settings, where most primary care patient services are delivered and where most training should occur. It does not foster innovation or enhanced quality of the graduate, and it lacks accountability for the type of product produced. Current national needs require changes in what training is paid for, and what product is produced.

Payment Modernization

Maintaining an outdated system of payment based on the model of acute hospital care and explicitly not paying for the costs of training in the nonhospital settings where most primary care occurs is problematic and outdated. Such policy creates a system that rewards procedural training at the expense of appropriately valuing primary care. Since primary care services are not commonly related to the cost of hospital inpatient care, medical education funding should go

directly to training programs, i.e., not through academic institutions, to ensure that the costs associated with appropriate training are reimbursed and accountability is assured. Additional financial incentives, such as scholarships, loan repayment and loan forgiveness, should be available to attract high quality U.S. medical school graduates into primary care residencies and future careers. Incentives for training in underserved areas should also be supported. These proven methods will produce a high quality primary care physician, and improve the distribution of primary care physicians nationally.

Accountability for the “Product”

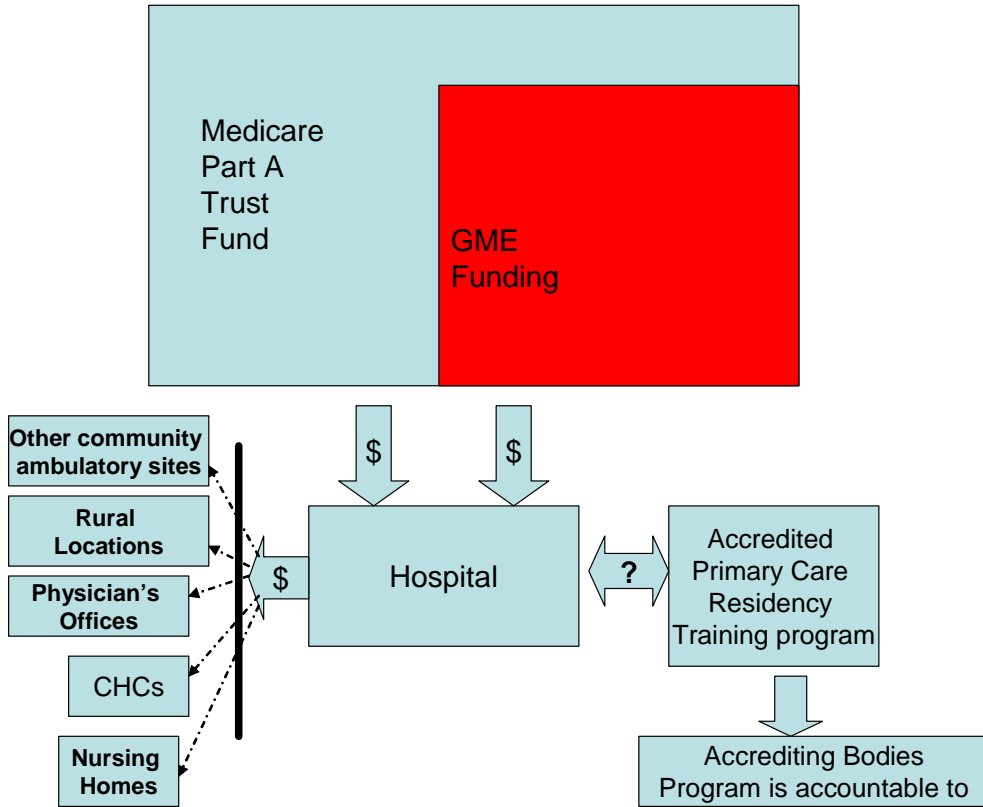
Current allocation of GME funds bears no relation to training nor to the physician that is produced. It is solely based on estimates of the “extra costs” a hospital may bear associated with having residents train in that hospital setting. There is currently no requirement that the GME funds be used for education. Directing the payment to the primary care training programs that, in concert with accrediting bodies, are responsible for the residents’ education, will achieve increased accountability while more efficiently funding the program to pay the costs and meet the requirements associated with primary care training.

Family medicine supports more consistency in the training of graduates. Such training should be predicated on competency-based curricula as well as a core set of skills, processes and knowledge. Training should: 1) be consistent with community needs, 2) support innovation to encourage enhanced quality and efficiency, 3) provide graduates with the ability to build and manage clinical practices – including ones delivering care in new models such as the patient-centered medical home, and 4) be able to adjust to meet current and future patient needs and medical knowledge.

Technical Issues for Modernization of Training

Increased funding directed toward primary care training programs should pay for training only up to initial board certification. Geographic variation in payment should be allowed to address varying costs of training in non-hospital settings. Medicare should continue to require hospitals to continue their relationships with primary care training programs. And hospitals should be rewarded on the basis of the number of primary care physicians they have helped produce.

Current Funding of Hospitals with GME



Primary Care GME Modernization Proposal

