Reform of the GME Payment System Can Help Meet the Nation's Healthcare Needs

The GME Initiative, a group of primary care leaders and educators from 14 states primarily in Western and Midwestern regions of the country, has identified priorities for reforming the Medicare Graduate Medical Education (GME) payment system. The current GME system is producing more sub-specialist physicians and fewer primary care physicians, resulting in a workforce imbalance that is detrimental to the health of the American public.

This brief outlines short- and long-term strategies to return to a balanced physician workforce and increase access to primary care in rural and underserved communities.

From 2008-2012 primary care residencies increased just 5 percent, while GME slots in dermatology grew by 10 percent, emergency medicine and plastic surgery by 17 percent, and neurosurgery by 41 percent.

21 percent of U.S. teaching hospitals do not currently produce any primary care physicians.

Organized in 2011, the GME Initiative has taken a lead role in advocating reform of the government's support of GME programs. As a result of the group's advocacy, the Institute of Medicine (IOM) studied GME in 2014 and highlighted the need for more transparency, accountability and reform of incentives that encourage hospital-based specialization over clinic-based primary care. The GME Initiative also hosted an educational forum in Washington in 2014, attended by more than 120 legislative health aides and others. In 2015 the GME Summit West was convened in Denver to prioritize concerns with the Medicare GME system and identify strategies for improvement.

SUMMARY

- **Increasing value in healthcare requires a strong foundation in primary care** and other generalist specialties (e.g. general surgery and psychiatry), which the United States currently lacks. A robust primary care system is essential to obtaining better care, healthier communities and lower costs.
- **The current GME system trains fewer primary care physicians each year** because of its current incentive structure.
- **Federal legislation—not more money—is needed to reverse the trends.** As the IOM noted, the current system requires both short-term and long-term fixes.
- **Reforming GME requires more transparency and accountability** for how GME dollars are spent, as recommended by the IOM.
- **The GME Initiative has a clear framework for solving the problem:** "Forty – Five – Flow – Plus" which aims for FORTY PERCENT of the physician workforce in primary care, measured FIVE years after medical school, with GME dollars FLOWING directly to primary care training programs, PLUS a variety of short-term fixes to boost recruitment efforts in rural areas.

The GME Initiative

Western and Midwestern Family Medicine Leaders for GME Reform

Without Reform, America Won't Have Enough Primary Care Physicians

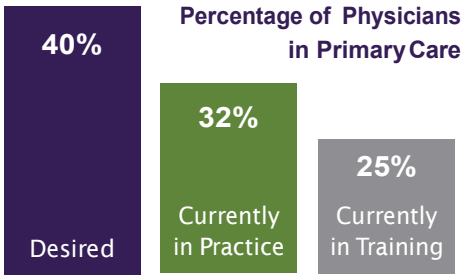
1. A strong primary care foundation is needed to meet the goals of better care, healthier communities and lower costs.

An increased number of primary care physicians in the United States improves health and lowers costs; whereas an increased number of sub-specialists is associated with worse health outcomes and higher costs.

Effective healthcare systems in other countries have a physician workforce comprised of 40-50 percent primary care, with lower costs and better health outcomes, in spite of a lower number of physicians per 100,000 people. The current U.S. physician workforce is just 33 percent primary care physicians.

Less than 25 percent of graduates from the U.S. GME system go on to practice primary care.

From 2008 to 2012 the GME system grew by 7.5 percent, but primary care residencies increased by just 5 percent. Slots in dermatology, meanwhile, grew by 10 percent, emergency medicine and plastic surgery at 17 percent, and neurosurgery at 41 percent.



2. GME payment favors hospital-based residencies.

Under current regulations, Medicare GME payments must be made to teaching hospitals, but considerable primary care residency training occurs in non-hospital locations such as outpatient clinics and community health centers.

3. Hospitals increase revenue by adding sub-specialty positions.

Hospitals receive higher payments for in-patient, specialty services and therefore prioritize specialty residencies over less lucrative out-patient primary care.

- 21 percent of U.S. teaching hospitals do not currently produce any primary care physicians.

A 1997 cap on GME positions, intended to control the cost of GME funding, has instead exacerbated the incentive to maximize potential revenue.

- Since the cap was implemented, the number of hospital-based specialty residencies has significantly increased. Between 2002 and 2007, hospitals opened 7,754 more new residency positions, 88.3 percent of which were in specialty care, despite the GME cap.

- Meanwhile, the number of family medicine residency positions has decreased (-1.4 percent) since 1997. While there has been a slight increase recently, it is not nearly as great as for specialties.

4. GME payments vary widely between regions of the country.

Direct GME (DGME) is calculated using complex formulas that cause huge variations between and within states. Payments are generally higher for states in the northeast and on the west coast compared to states in the middle of the country, and do not correlate with the cost of running a residency.

- A 2013 report shows the average GME payment per resident per year in states such as New York, Massachusetts and New Hampshire is $130,679 - $155,135. This compares to $38,294 - $83,762 in western states such as Colorado, New Mexico, and Utah.

5. Reform of the GME payment system is hindered by complexity and lack of transparency.

Complex formulas are used to calculate GME payments, and accountability to the public is absent due to lack of transparency.

For example, Indirect GME (IME) is intended to offset teaching hospital costs for inefficiencies of care by residents, but it actually is used to subsidize safety net services in communities with high levels of unreimbursed care. While this may be needed and important, it is far from the original intent of GME funding.

6. Government regulations obstruct the development of rural training programs.

Rules from the Center for Medicare & Medicaid Services restrict the ability of many rural programs to qualify for Medicare GME payments, which are calculated differently for some rural hospitals, resulting in substantially less GME funding.

7. Successful programs for training primary care physicians in Community Health Centers require sustainable funding.

A pilot program for funding Teaching Health Centers (THC), funded through HRSA as an alternative to Medicare GME, has been highly successful. Teaching Health Center funding through HRSA requires congressional reauthorization; the funding may not be reauthorized beyond 2017. Moving THC funding into Medicare could provide long term and sustainable funding for these residencies.

For Additional Information
go to www.cofmr.org

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