

## Defining a Role for Managed Care in Residency Programs

Like private-practice attending physicians, residents are being affected by the growing managed care phenomenon. Experimental, state-controlled health maintenance organizations are beginning to absorb increasing numbers of Medicaid recipients. These patients, once available to residents for clinical teaching, are usually seen exclusively by their assigned attending physicians in managed care plans, where the strict interpretation of board eligibility or certification for "approved physician providers" restricts house staff access to former Medicaid patients.

Since 1992, exploration of ways to reduce public health spending by state and local governments has led to 41 waivers from the US Health Care Financing Administration. These waivers authorize significant departures from traditional Medicaid funding formulas and permit states to develop individual solutions to the unsustainable expansion of their health care budgets.

While no two states have implemented identical plans, a reliance on managed care models has emerged as the common feature. However, federally sponsored managed care plans still face the difficult challenge of balancing quality of care and cost containment.

Yet these two parameters, while critical, ignore a key factor of great interest to house staff: managed care's impact on residency education. Unfortunately, this factor has received little attention in the national health system reform dialogue.

Psychiatry programs have been among the first to experience managed care's unfamiliarity with graduate medical education training. Some psychiatric patients in capitated managed care plans have been specifically removed from the residency and fellowship teaching pool. However, no training program in any specialty can expect immunity from managed care's potentially corrosive effect on clinical education.

For example, in New Jersey, 400 000 Medicaid patients will be subject to "mandatory reenrollment" from Aid for Families With Dependent Children/

Medicaid to state-approved managed-care organizations during a 2-year period. As the residency clinics empty, there are few inducements for managed care leadership to reintroduce meaningful house staff roles in the care of these former Medicaid patients.

Can insurance networks be modified to permit house staff participation? Managed care plans such as Kaiser-Permanente have shown that in the proper setting these plans can provide quality patient care and manage costs while supporting residency training. These exceptional programs deserve closer study.

Aware of the importance of managed care's role in graduate medical education, the AMA-RPS Assembly adopted a resolution at its Annual Meeting in June supporting a campaign to inform state and federal legislators of the importance of encouraging managed care's participation in graduate medical education and of the potential adverse consequences of managed care's influence on residency education. The AMA House of Delegates adopted a resolution to continue to gather and make available information on the possible advantages and disadvantages of managed care and to emphasize professionalism, patient and physician autonomy and rights, and practical assistance to physicians in AMA advocacy efforts related to managed care.

It is critical that house staff play an active role in this campaign. By joining the ongoing efforts of practicing physicians, residents can remind policymakers that even modest guarantees of future health care quality largely depend on the integrity of clinical training programs.

As local health care delivery systems emerge as blueprints for reform at the national level, analysis and standardization of managed care's role in graduate medical education warrants serious consideration indeed. Residents are uniquely positioned to appreciate the momentum of managed care in our profession; managed care's reciprocal acknowledgment of graduate medical education's contribution to quality care would also be welcome.

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