

## **Reform and Sustain Graduate Medical Education Financing and Ensure an Adequate Physician Workforce**

*This document was developed jointly with the Alliance for Academic Internal Medicine (AAIM)*

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According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of more than 90,000 physicians by 2020; about half of the shortage will be in general surgery and medical specialties, while the other half will be in primary care. If we are to address the physician workforce crisis, full funding for graduate medical education (GME), coupled with a more strategic approach to using that funding, is critical. In addition, funding for federal programs aligned to improving the primary care workforce and ensuring access to primary care physicians must be preserved.

GME is the process by which graduated medical students progress to become competent practitioners in a particular field of medicine. These programs, referred to as residencies and fellowships, allow trainees to develop the knowledge and skills needed for independent practice. GME plays a major role in addressing the nation's workforce needs, as GME is the ultimate determinant of the output of physicians. Recognizing the important public good GME provides to the nation and by extension in helping to ensure needed care to patients, the federal government is the virtual sole explicit provider of GME funding, with the majority of support coming from Medicare which currently provides approximately \$9.5 billion annually.

### **How is GME financing currently structured?**

The costs of GME are recognized by Medicare under two mechanisms: direct graduate medical education payments (DGME) to hospitals for residents' stipends, faculty salaries, administrative costs, and institutional overhead; and an indirect medical education (IME) adjustment developed to compensate teaching hospitals for the higher costs associated with teaching. Current Medicare GME payments are based on calculations originally set in 1984 and do not account for additional direct training costs incurred by teaching hospitals, affiliated medical schools, and practices that have surfaced as GME has evolved during the last 25 years. Additionally, the number of Medicare-supported positions is capped at 1996 levels. With sharply increasing numbers of allopathic and osteopathic medical students and looming physician workforce shortfalls, especially in primary care, the current "choke-point" in the physician supply chain is residency training. This year there were more U.S. medical students who did not receive residency positions through the National Residency Matching Program (NRMP) than available positions after the match. It is imperative that we thoughtfully preserve this vital component of medical education and maintain adequate training positions for our medical graduates.

Much attention has been focused on Medicare's support of GME, especially monies for IME. In fact, the President's Fiscal Year (FY) 2014 budget proposes cuts to IME payments by 10 percent over 10 years starting in FY 2015. And, the budget sequester has already imposed a two percent across-the-board cut to Medicare program payments—including GME. The Medicare Payment Advisory Commission (MedPAC) has stated that 50 percent of the IME adjustment represents overpayment to hospitals. While we agree that the costs covered by the IME adjustment have decreased, we also contend that costs related to DGME expenditures have risen, primarily due to increased regulatory demands. DGME reimbursement amounts were set in 1986 and have been adjusted only for inflation. Studies evaluating the costs of residency programs support higher DGME costs over time. We are concerned that because Medicare payments have not kept pace with the rising costs associated with DGME and given this program's determinant role in the physician workforce, it is that much more critical that any cuts to DGME or IME currently in effect or under consideration be withdrawn immediately.

### **What strategic reforms to GME financing are we proposing?**

**Lifting the Caps on GME:** The existing caps on the number of Medicare-funded GME positions available makes it impossible to fund GME training positions in the numbers needed to slow or reverse growing shortages of physicians in primary care and other fields. The caps should be strategically adjusted to align spending with workforce policy goals. There are several introduced bills that we have endorsed in both the House and Senate that would increase the number of Medicare-supported training positions for medical residents who choose careers in primary care. S. 577, H.R. 1180, and

H.R. 1201 would provide for, among other things, approximately 15,000 additional GME positions for medical residents and require at least 50 percent of the new positions to be allocated to specialties, such as primary care, that are currently facing a shortage.

**Establish an All-Payer GME System:** ACP and AAIM, along with many other medical associations, have long-supported the concept of an all-payer GME system. Most proposals for the establishment of an all-payer system would create a GME trust fund in which Medicare and Medicaid would continue to contribute to GME, but private payers would do so as well through a modest assessment on health insurance premiums. Such a funding system would be more equitable and provide stability to the GME funding stream. An all-payer system could also be an important contribution to deficit reduction by spreading the responsibility for funding of GME to all who benefit from it instead of the federal government bearing a disproportionate share of the cost as it does today. The all-payer system should be linked to the nation's health care workforce needs to ensure an adequate supply of physicians with an appropriate specialty mix and distribution.

**Support Reform Studies:** The Institute of Medicine (IOM) has convened a special committee to assess current GME funding mechanisms and explore possible reforms, a process we support. It is important that this process include an accurate assessment of current training costs, establish a mechanism for monitoring this in the future, seek ways to minimize inequalities across the system, encourage training programs in underserved areas and regions, and structure GME funding to help address physician workforce needs. The IOM and Congress should also consider additional funding sources for GME such as private payers since, as a public good, GME benefits all of society, not just Medicare patients.

### **What other federal programs are important in ensuring an adequate physician workforce?**

There are numerous federal programs and initiatives specifically designed to help ensure an adequate primary care workforce. And, because it is proven through hundreds of studies that access to primary care not only improves health outcomes but also reduces costs, it is in the best interest of Congress and the public to see to it that these programs are fully funded going forward. Examples include:

- **Section 747, Primary Care Training and Enhancement/Title VII** is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine and promote interdisciplinary training that helps prepare physicians to work with other health professionals, such as physician assistants, patient educators and psychologists.
- **National Health Service Corps (NHSC)** funds training for thousands of primary care clinicians who provide care to tens of millions of persons in underserved communities by providing scholarships and loan forgiveness to primary care physicians who serve in underserved communities.
- **National Health Care Workforce Commission** is a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy, analyzing and making recommendations for eliminating barriers to entering and staying in careers in primary care. However, to date, Congress had not provided the necessary funding for the Commission to be convened, preventing this critical advisory body from embarking on its vital mission.

### **What are ACP members asking Congress to do?**

- ✓ Preserve funding for Graduate Medical Education in FY2014 and halt cuts to GME under sequestration.
- ✓ Enact legislation that will increase the number of GME training positions, especially in primary care specialties. Specifically, co-sponsor the Resident Physician Shortage Reduction Act (S.577 and H.R. 1180); House members should co-sponsor the Training Tomorrow's Doctors Today Act (H.R. 1201) and Senate members should introduce and co-sponsor a companion bill.
- ✓ Introduce legislation to support GME financing reform by introducing more transparency and accountability and requiring that all payers contribute to GME funding.
- ✓ Ensure full funding for other vital federal physician workforce programs such as Title VII, and the NHSC.
- ✓ Fully fund the National Health Care Workforce Commission, which has yet to become operational because Congress has not provided the necessary funding.

For additional information on ACP's views regarding GME, please read its most recent paper at: [http://www.acponline.org/advocacy/where\\_we\\_stand/policy/gme\\_policy.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/gme_policy.pdf).