

Reform and Sustain Graduate Medical Education Financing and Support Other Programs to Ensure an Adequate Physician Workforce

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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, sufficient 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 currently financed?

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.

Much attention has been focused on Medicare's support of GME, especially monies for IME. The Medicare Payment Advisory Commission (MedPAC) has stated that 50 percent of the IME adjustment represents overpayment to hospitals and should be distributed to hospitals as an incentive program tied to educational objectives. While we agree that some of the costs covered by the IME adjustment have decreased, we also contend that other 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. In fact, the increase in DGME costs appear to roughly offset the decrement in IME costs, such that across the entire system, current reimbursement does approximate actual costs of training residents (recognizing that significant variation exists across different states and institutions). Significant reductions in IME payments would result in a failure to cover necessary direct costs and could have a devastating effect on GME programs.

The Institute of Medicine (IOM) has convened a special committee to assess current GME financing mechanisms and explore possible reforms, and we support that effort. This study by IOM has not yet been released but is expected to be soon. In the meantime, we urge IOM to include the following in its study: an accurate assessment of current training costs, establish a mechanism for monitoring this in the future, seek to minimize inequalities across the system, and encourage training programs in underserved areas and regions, structure GME funding to help address physician workforce needs, and evaluate changes in direct medical education costs, which are heavily influenced by new accreditation requirements.

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 lifted to align spending with the nation's healthcare workforce policy needs. New primary care slots should also be added in underserved geographic areas.

We support legislation that has been introduced 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. The *Resident Physician Shortage Reduction Act, S. 577, H.R. 1180*, introduced by Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) and by Representatives Joseph Crowley (D-NY) and Michael Grimm (R-NY) and the *Resident Physician Shortage Reduction Act, H.R. 1201*, introduced by Representatives Allyson Schwartz (D-PA) and Aaron Schock (R-IL), would provide for 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 face a shortage.

Establish an All-Payer GME System: ACP and AAIM, along with many other medical associations, have long-supported 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.

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

Without a robust primary care physician workforce, the nation's health care system will become increasingly fragmented and inefficient. Hundreds of studies show that the numbers and percent of physicians in primary care disciplines practicing in a region, state or country is positively associated with better health outcomes and lower costs. See: http://www.acponline.org/advocacy/current_policy_papers/assets/primary_shortage.pdf. Unless changes to the U.S. health care system are met by adequately funded GME programs as well as an adequate supply of well-trained primary care physicians, increasing access to high quality and affordable health care will not be possible. Congress should fund the following programs at the levels indicated:

Section 747, Primary Care Training and Enhancement/Title VII, at \$71 million, 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), at \$810 million, 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, at \$3 million, 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 advisory body from embarking on its vital mission.

What are ACP members asking Congress to do?

- ✓ Preserve funding for Graduate Medical Education in FY2015; stop the 2 percent cut to GME under sequestration; and protect IME from cuts.
- ✓ Cosponsor and urge enactment of legislation that will strategically increase the number of GME training positions in primary care specialties (including internal medicine) and other specialties facing shortages, such as those included in *S.577, H.R. 1180* and *H.R. 1201*.
- ✓ 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 including 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.