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Graduate Medical Education (GME) Financing

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

Congress should pass legislation to strategically increase the number of GME trained positions in specialties facing shortages including internal medicine, support and expand teaching health centers, ensure overall GME funding is sufficient to train enough physicians, and broaden the base of GME financing.

Senators and Representatives should cosponsor and then pass legislation—including S.1148/H.R.2124 and H.R. 1117—to strategically increase the number of GME training positions in primary care specialties (including internal medicine) and other specialties facing shortages. Congress should ensure that overall GME funding for FY2016 is sufficient to train enough physicians, with the skills needed, to meet increased demand. It should broaden the GME financing base by establishing an all-payer system where Medicare, Medicaid and private payers would contribute to GME funding as a public good.

What's it all about?

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. The federal government is the largest explicit provider of GME funding, with the majority of support coming from Medicare, which currently provides approximately \$9.5 billion annually. 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. The number of Medicare-supported positions at institutions is capped at 1996 levels. The existing caps on the number of Medicare-funded GME positions have been criticized as not allowing GME training positions to increase by the numbers needed to slow or reverse growing shortages of physicians in primary care and other specialties.

In a 2010 report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated that 50 percent of the IME adjustment represents overpayment to hospitals and recommended using those funds to establish a performance-based GME program. Since then, it has been identified as an opportunity for deficit reduction, although the MedPAC recommendation was for a *budget neutral redistribution* of IME dollars to a performance based pool, not an overall reduction in IME or in total GME funding. The President's 2016 Budget proposes to cut \$16.3 billion over 10 years by reducing indirect medical education (IME) payments (part of GME) by 10 percent.

In 2014 the Institute of Medicine (IOM) released a report recommending that Congress overhaul the federal financing and governance of GME, including the creation of new infrastructure for fund distribution and research into improved payment models. The report sparked criticism from various teaching programs, medical colleges, and physician membership organizations because it called for no increase in overall GME funding for the next decade, other than annual inflation updates, and also would redistribute payments for existing GME positions in order to fund a performance-based innovation pool. In addition, the IOM's statement that there is no "credible data" of physician shortages, especially in primary care, was challenged as being inconsistent with a large body of evidence that shows that the United States is not training enough primary care physicians for adults to meet increased demand, that tens of millions of Americans have poor access to primary care, and that there are shortages in many other physician specialties as well.

- Read the IOM [report](#) on governance and financing of GME.
- Read the MedPAC [recommendations](#) on GME financing.

What's the current status?

The number of available residency training positions funded by Medicare has been capped at 1996 levels since the passage of the Balanced Budget Act of 1997. 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. Several bills were recently introduced in the 114th Congress that would increase the number of Medicare-supported training positions with preference for primary care and other specialties facing shortages.

- The Resident Physician Shortage Act (H.R. 2124), introduced by Reps. Crowley (D-NY) and Boustany (R-LA), would increase the number of Medicare-supported training positions for medical residents by 3,000 per year over five years (approximately 15,000 slots) with one-third going to teaching hospitals over their cap and requiring at least 50 percent of remaining new positions to be allocated to specialties facing a current shortage. Read ACP's [letter](#) of support. Similar legislation was introduced in the Senate (S. 1148) by Sens. Nelson (D-FL), Schumer (D-NY), and Reid (D-NV). Read ACP's [letter](#) of support.
- The Creating Access to Residency Education (CARE) Act (H.R. 1117), was introduced by Reps. Castor (D-FL) and Heck (R-NV) establishing federal grants to support the creation of new medical residency positions, with priority for primary care and areas for significant need. Read ACP's [letter](#) of support.

Why should the 114th Congress address it?

Cuts in GME funding could exacerbate the growing shortage of physicians and undermine the ability of residency programs to train physicians with the skills needed to meet societal needs. Currently, the types of residents trained in teaching hospitals are determined by the staffing needs of the particular hospital and the number of funded positions set by the cap in 1996. Although Medicare GME funds are supposed to help develop the future physician workforce, the dollars are not prioritized based on local, regional, or national workforce needs.

What's ACP's view?

GME funding needs to be sustained, and increased on a prioritized basis, to train more physicians in the specialties in greatest need. It is especially important that GME dollars support training of more internal medicine physician specialists. *Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.* Internal medicine physicians will be especially needed as the population ages and more patients acquire chronic diseases.

Further, significant reductions in IME payments could have a devastating effect on GME programs. While we agree that some of the costs covered by the IME adjustment have decreased, other costs related to DGME expenditures have increased while DGME reimbursement, set in 1986, has only been adjusted for inflation. Data suggests that the increase in DGME costs appear to roughly offset the reduction in IME costs, such that across the entire system, current reimbursement does approximate actual costs of training residents.

The concept of a performance-based GME payment system is worth exploring but such a system must be thoughtfully developed and evaluated with input from a variety of stakeholders including physicians involved in medical education. ACP also supports increased training in ambulatory settings including community-based training programs. We support the Teaching Health Center Graduate Medical Education (THCGME) program and were pleased to see the recent enactment of legislation that provided \$60 million in mandatory funds for the program for FY2016 and FY2017. However, ACP believes that Congress should consider proposals to broaden the program and extend it beyond FY2017.

In addition, ACP believes that GME is a public good— it benefits all of society, not just those who directly purchase or receive it. All payers depend on well-trained medical graduates, medical research, and technical advances from teaching programs to meet the nation's demand for high quality and accessible care, and accordingly, all payers should contribute to GME funding.

- Learn more about ACP's [views](#) on how to reform GME, its [statement](#) on the IOM report, and a [side-by-side](#) comparing the IOM recommendations with ACP policies.
- Read ACP's [policy paper](#) on GME and [evidence review](#) on how a shortage in primary care physicians affects cost and quality.

Who can I contact to learn more?

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