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Graduate Medical Education (GME) Financing and Reform

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

Senators and House members should develop and introduce legislation to reform Graduate Medical Education to prioritize funding toward physician specialties facing shortages including primary care internal medicine, to improve transparency, and to ensure sustainable and broadly supported funding by all payers going forward, as described below in the "What's ACP's view" section.

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 $10 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 2017 Budget proposes to cut $17.8 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. A recent report prepared for the Association of American Medical Colleges (AAMC) states that the nation faces a severe shortage of primary care physicians, estimated to be 14,900-35,600 by 2025.

- Read the IOM report on governance and financing of GME and ACP's statement on the IOM report.
- Read the MedPAC recommendations on GME financing.
- Read the report prepared for the AAMC.

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—perhaps by over 30,000 physicians, the current "choke-point" in the physician supply chain is residency training.

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?

Increase the number of GME slots by at least 3,000 per year over five years (approximately 15,000 slots) for specialties facing shortages, including internal medicine. Fully fund and support GME, including lifting the GME caps as needed to permit training an adequate number of primary care physicians, including internal medicine specialists, and physicians in other specialties facing shortages. 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.

Combine DGME and IME into a single, more functional payment program, and broaden the GME financing structure to include all payers. Consolidating DGME and IME into one payment by using a single per resident amount with a geographic adjustment would increase functionality and improve transparency. Have all payers—both public and private—contribute to a financing pool to support residencies that meet the nation's policy goals related to supply, specialty mix, and site of training. ACP believes that GME is a public good—it benefits all of society, not just those who directly purchase or receive it. All payers and the patients insured by them 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.

Transparency: Allocate GME funds transparently and specifically to activities that further the educational mission of teaching and training residents and fellows. GME funds should follow trainees into all training settings rather than being linked to the location of service relative to the teaching institutions. Medicare GME payment information should be made publicly available in a concise, timely and easily accessible report to ensure that these funds are used for the education and training of residents.

- View ACP's support letter for the Tomorrow's Doctors Today Act, H.R. 4774
- View ACP's support letter for the Creating Access to Residency Education Act of 2015 (CARE Act), H.R. 1117.
- View ACP's support letters for the Resident Physician Shortage Reduction Act of 2015, H.R. 2124/S. 1148.

Who can I contact to learn more?

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