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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 where millions of patients lack access, including internal medicine specialists trained in comprehensive primary care; to improve transparency; to ensure that enough physicians are being trained with the skills needed to treat an aging population with multiple chronic diseases; to support funding for the VA's role in medical training, and to ensure sustainable and broadly supported funding by all payers going forward, as described below in the "What is ACP Asking of Congress" 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 (over $15 billion annually), with the majority of support coming from Medicare. 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 the shortages of physicians in primary care and other specialties.

The Veterans Administration (VA) also plays a significant role in training physicians, and that has been part of its mission dating back to 1946. The Veterans Health Administration (VHA) is the second largest federal payer for medical training, after Medicare. In the academic year 2016-17 alone, the VA trained a combined 68,711 medical students, residents, and fellows and approximately 70 percent of all physicians in this nation train in the VA at some point in their careers. Many wind up practicing medicine within the VA, or otherwise providing care to veterans as permitted under federal law.

There is compelling evidence that tens of millions of Americans have poor access to primary care, and that access to primary care is associated with better outcomes and lower costs. A 2018 report from the Association of American Medical Colleges (AAMC) estimates there will be a shortage of 14,800 to 49,300 primary care physicians by 2030. There are currently 7,176 designated primary care health professional shortage areas, and according to HRSA it would take approximately 14,741 additional primary care physicians to eliminate them. In addition, with an aging population with higher incidences of chronic diseases, it is especially important that patients have access to physicians trained in comprehensive primary and team-based care for adults—a hallmark of internal medicine GME training.

What's the current status?

In FY 2019, the President's budget request proposes consolidating Federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospitals GME program into a single grant program for teaching hospitals, which would amount to cuts across-the-board to GME of roughly $48 billion over ten years. Previous budgets from the Office of the President have also proposed cuts of more than $17 billion over 10 years by reducing IME payments 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 including ACP 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 other evidence that shows that the United States is not training enough primary care physicians for adults to meet increased demand. Subsequently, in 2014, the House Energy and Commerce Committee put out a "call to action" inviting stakeholders to provide input on reforms to GME, to which ACP submitted comments, but the committee has not followed up with any further action.

Why should the 115th Congress address it?

Cuts in GME funding could exacerbate the growing lack of access to primary care and undermine the ability of residency programs to train physicians with the skills needed to meet the needs of an aging population with more chronic diseases. In recent years, a confluence of proposals have been put forth to cut GME/IME funding through various Presidents' budgets. And, Congress has yet to develop legislation to reform GME, a process they themselves started over four years ago.

What is ACP asking of Congress?

In 2016, ACP and AAIM developed a comprehensive proposal for GME innovation and reform. We urge Congress to develop legislation, inclusive of the policies outlined below, to support training of internal medicine specialists with the skills needed to care for an aging population with multiple chronic diseases and to alleviate the growing problem of millions of Americans lacking access to primary care:

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, as contained in the Resident Physician Shortage Reduction Act of 2017, H.R. 2267/S. 1301. GME funding needs to be sustained and increased on a prioritized basis, to train more physicians in the specialties with the skills and training needed to care for an aging population with multiple chronic diseases, including training of more internal medicine physician specialists.

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. 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.

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.

Support continued adequate funding for the VHA and its substantial contributions to the ongoing training of the next generation of physicians. Any legislation under consideration by Congress to reform or consolidate care in the VHA should not undermine the VA's ability to continue to provide such medical training.

Senators and representatives should cosponsor the Resident Physician Shortage Reduction Act of 2017 (H.R. 2267 in the House and S. 1301 in the Senate). View ACP's support letter for H.R. 2267.

Who can I contact to learn more? advocacy@acponline.org; Digital version of this issue brief can be found at: https://www.acpservices.org/leadership-day/policy-priority-issues