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Health Policy Brief

AUGUST 16, 2012

Graduate Medical Education. A debate continues over the size and scope of federal subsidies to support residency training of the nation's physicians.

WHAT'S THE ISSUE?

The Department of Health and Human Services (HHS), through the Centers for Medicare and Medicaid Services, is the single largest funder of graduate medical education (GME). This is the training that medical school graduates receive as residents in more than 1,000 of the nation's hospitals, known as "teaching" hospitals. These trainees are a key part of the labor supply at these hospitals.

Now, amid efforts to reduce federal spending, these GME monies face possible reductions and other changes. The Obama administration and some members of Congress want to cut back on GME funding. Many hospitals, medical schools, and medical associations are opposed, and they actually want to increase funding and residency slots to train more doctors. Besides the costs of the public subsidies to medical education, other issues at stake include whether or not the nation is training enough doctors or other health professionals, and what the impact would be of increased accountability for the subsidies.

This Health Policy Brief provides background on graduate medical education funding and delineates the arguments on various sides of the debate.

WHAT'S THE BACKGROUND?

In the United States, students training to be physicians attend four years of medical school, typically paying most of those costs directly or through loans. Upon graduation, they receive their MD degrees and finish their preparation as residents. During this period, they see and treat patients under the supervision of more seasoned physicians. This training usually takes place in hospitals. On average, physicians spend four years in graduate training, although the length of training in highly specialized fields is several years longer.

PAYING FOR EDUCATION: Although the federal government, as noted, is the largest single supporter of graduate medical education, overall support for GME comes out of a number of separate public and private pots. Each year the federal government contributes about $9.5 billion in Medicare funds, and approximately $2 billion in Medicaid dollars, to help pay for GME. The federal government also funds GME in children's hospitals via a new program called Teaching Health Centers GME, which trains residents in community-based ambulatory settings; and through contributions from other agencies, including the Department of Defense, the Department of Veterans Affairs, the Health Resources and Services Administration, and the National Institutes of Health.

More than 40 states also paid about $3.78 billion through their Medicaid programs to support GME in 2009 (at least half of that amount was derived from federal matching payments). Since then, many states have reduced their support for advanced medical

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training. Private insurers, meanwhile, support GME to some degree through payments they negotiate with teaching hospitals. These payments are typically higher than what they pay other hospitals.

DIRECT AND INDIRECT COSTS: Medicare supports GME through two separate methodologies when calculating payments to hospitals: *direct payments* to pay the salaries of the residents and the supervising physicians' time; and *indirect payments* to subsidize other hospital expenses associated with running training programs, such as longer inpatient stays and more use of tests. These payments are based, in part, on the number of residents a hospital trains and the number of Medicare patients it treats.

Of the estimated $9.5 billion in Medicare funds spent on GME in 2010, approximately $3 billion went for direct payments and $6.5 billion went for indirect payments. The indirect medical education calculations are complicated and controversial. The Medicare Payment Advisory Commission (MedPAC), a group that advises Congress, estimates that indirect payment levels may be $3.5 billion higher than actual indirect costs. Overall, federal spending for GME has been increasing for decades.

WHAT ARE THE ISSUES?

A number of issues have emerged in the debate over how federal and state funds should be used to subsidize physician training. Among key questions are whether the nation is training enough doctors and, if so, of the types that are needed; whether federal support overall for graduate medical education is too costly; whether some federal support should be directed to funding training of other types of health care professionals; and whether federal support should be tied to achieving certain outcomes, such as achieving a higher level of competence among trainees.

GME FUNDING IS COSTLY: There are approximately 115,000 physicians currently in residency programs. Federal support translates to about $100,000 per resident per year. Adding in state Medicaid payments, and considering the length of time that residents spend in training, the public investment per physician in training comes to half a million dollars or more. Earlier deficit reduction efforts sought to constrain federal GME expenses. For example, the Balanced Budget Act of 1997 placed a limit on the number of Medicare-supported residency slots, tied to the number of residents hospitals reported having in 1996. This freeze, or cap, on Medicare-supported residency slots has remained in place ever since, even though exemptions and exceptions have permitted steady growth.

Several recent proposals have been made to lower federal contributions to GME. In 2010 the National Commission on Fiscal Responsibility and Reform (the Simpson-Bowles Commission) recommended reducing both direct and indirect GME payments. Under the commission's proposal, direct GME payments would be reduced to equal 120 percent of the national average of a resident's salary, with subsequent adjustments based on inflation. Indirect GME payments would be cut to reflect actual costs more accurately. Total savings in direct and indirect GME costs would be $6 billion in 2015 and up to $60 billion by 2020. In 2011 President Barack Obama proposed reducing Medicare indirect GME support and cutting in half GME funding for children's hospitals. Congress has not acted on either of these proposals.

GME FUNDING AND PHYSICIAN SUPPLY: The number of physicians and the ratio of physicians to general population have increased over the past several decades. However, with the expansion of insurance coverage under the Affordable Care Act, there are concerns about whether the number of physicians will be sufficient to meet the needs of newly covered individuals (Exhibit 1). This topic is highly controversial, however, because of conflicting views about how the number of providers needed is calculated and how the workforce is defined, particularly because nurse practitioners and physician assistants are increasingly performing work traditionally done by physicians. Concerns also have been raised that the greater the number of physicians, the more health care is supplied to people, including much care that is unnecessary or even harmful.

Those who are concerned that the supply of doctors may be insufficient worry that decreased GME funding would conflict with efforts to expand the nation's physician supply, including plans to open up 18 new US medical schools. Combined with an annual influx of about 6,000 graduates of foreign medical schools (referred to as international medical graduates, many of whom are US citizens), there may be too few advanced training positions to accommodate all of these new doctors. In Florida, for example, four new medical

$9.5 billion

GME support from Medicare
Every year the federal government spends about $9.5 billion in Medicare funds to help pay for graduate medical education.

"Several recent proposals have been made to lower federal contributions to graduate medical education."

schools are being planned, but only modest efforts are under way to increase the number of available GME positions.

Some medical education leaders want to remove the 15-year-old cap on Medicare-funded residency slots and would like to ensure that federal GME funding is sufficient to meet the growth in numbers of medical school graduates. In late 2011 the Resident Physician Shortage Reduction Act was introduced to increase the number of Medicare-funded residency positions by 15 percent. Although the bill was debated in the Senate in late 2011, it did not pass.

115,000

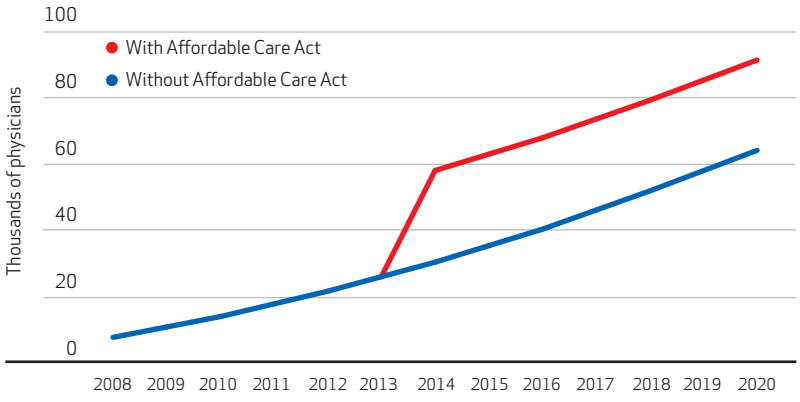
Residents in training
Approximately 115,000 physicians are currently in residency programs in the United States.

GME FUNDING AND PRIMARY CARE: Regardless of the size of total public GME funding, many analysts believe that more could be done to target the monies to expanding primary care in the United States. Despite broad agreement on the need for growth in the primary care workforce, the number of specialist physicians still outweighs the number of primary care doctors by about two to one. This contrasts with the situation in many other countries, where numbers of primary care physicians and specialists are roughly equal. The relatively weak role of primary care in US health care may help explain why other countries achieve better and more cost-effective health outcomes than the United States.

There are several reasons for the disparity in numbers of specialists versus primary care providers: Specialists earn considerably more than do primary care doctors, and specialists often perceive the work they do for patients as being more complex and intellectually challenging than primary care.

EXHIBIT 1

Projected Gap in Number of US Patient Care Physicians, 2008–20



SOURCE Darrell G. Kirch, Mackenzie K. Henderson, and Michael J. Dill, "Physician Workforce Projections in an Era of Health Care Reform," *Annual Review of Medicine* (2012) 63:435–45. Epub 2011 Sep 1.
NOTE Numbers shown represent gap between projected number of physicians needed and supply.

The American Academy of Family Physicians has argued that any increase in the number of Medicare-funded GME training slots should be dedicated to primary care. Specialty societies strongly oppose the idea, however. Congress, meanwhile, has been reluctant to wade into issues that divide primary care physicians and non–primary care specialists.

PUBLIC INVESTMENT IN OTHER PROFESSIONS: The bulk of governmental support for health professions education goes to GME, and the vast majority of GME funding goes to training doctors. Whatever the historical reasons for these decisions, today's policy makers must consider the fact that there are many more health professions—and health professionals—beyond medicine whose education and training are essential to the care provided to patients in government-sponsored plans.

Some of the newer federal efforts to fund GME—the Teaching Health Centers program, for example—make funding available for primary care training of nurse practitioners and physician assistants. What's more, in its proposed 2013 budget, the Obama administration proposed cutting Medicare GME payments but slightly expanding funds to train these primary care providers.

In late July 2012 HHS announced that it was awarding about $200 million to five hospitals to help train additional advanced practice registered nurses. This demonstration project is designed to place more nurse practitioners, clinical nurse specialists, certified nurse anesthetists, and certified nurse midwives into the workforce. Although perhaps indicating a new direction in federal support for the nonphysician workforce, overall these investments total only a fraction of the public support given to physician training.

GME FUNDING AND GEOGRAPHIC DISPARITIES: Many people, especially in rural areas, do not have sufficient access to medical specialists. Large GME payments to teaching hospitals that are located primarily in urban areas may be exacerbating the maldistribution problem, because physicians tend to practice where they do their residencies.

Over the years, policy makers have sought to address this imbalance. The National Health Service Corps encourages residents to work in underserved communities by providing either loan repayments or scholarships during up to four years of training. Policy makers have also given residency cap exemptions to rural hos-

pitals. Another idea is to create new residency slots in rural hospitals that are linked via telemedicine to urban hospitals.

GME AND QUALITY IMPROVEMENT: Some suggest that federal GME subsidies should be tied to societal goals, such as improving the quality of health care. Although the nation's teaching hospitals have taken strides to improve education, Medicare's GME funding carries no requirements to encourage residents to become primary care physicians rather than specialists. Nor are there requirements concerning the quality of training, performance of residents or their overall programs, or the outcomes of patient care.

To address some of these issues, MedPAC in 2010 recommended establishing a "performance-based incentive program," in which a portion of Medicare indirect medical education payments would be made contingent upon reaching desired educational outcomes and standards. Some of these goals would be to make sure that trainees had appropriate interpersonal and communication skills to care for patients and to operate in teams with other health care workers; that they had a strong sense of professionalism; and that they were trained to practice in systems where community-based ambulatory care was integrated with hospital care. The cost of this performance-based incentive program would be covered by funds that teaching hospitals receive in excess of actual indirect costs.

Recently, the Graduate Medical Education Reform Act was introduced by Sens. Jack Reed (D-RI) and Jon Kyl (R-AZ). The bill would not cut GME funding but, rather, would enable hospitals to compete for additional GME funding by linking their residency programs to performance goals. The legislation directs the health and human services secretary to develop measures of patient care priorities, such as coordination of care across various settings or the use of health information technology. Then, 3 percent of a teaching hospital's indirect medical education funding would be at risk, with the hospital able to achieve the full amount only if it met all of the criteria.

In addition, the Physician Shortage Reduction and Graduate Medical Education Accountability and Transparency Act was recently introduced by Reps. Aaron Schock (R-IL) and Allyson Schwartz (D-PA). The bill would expand the number of Medicare-supported residency training positions by 15,000. The proposal would establish measures to determine the extent to which training programs improve patient care, such as by providing training in a variety of settings, using health information technology, and developing interdisciplinary care teams.

WHAT'S NEXT?

Under the budget law enacted in August 2011, Congress faces a deadline of January 1, 2013, for making major cuts in all sectors of federal spending or faces draconian automatic cuts, known as "sequestration." Parties with stakes in GME financing are studying, positioning, and advocating a variety of recommendations. Policy makers can expect to hear a wide assortment of opinions. Hoping to inform the discussion with an unbiased perspective, the Macy Foundation has awarded $750,000 to the Institute of Medicine to study and issue a report on GME financing to be issued in 2014.

The unsettled state of GME financing provides an opportunity for care delivery sites, professions, educators, and policy makers to evaluate the number and types of health care professionals that will be needed in the future; how they should be educated and trained; how physicians in particular should be educated and trained; and the most appropriate amount of and use of public funding for these purposes.■

RESOURCES

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New medical schools
Plans are under way to open up 18 new medical schools in the United States.

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Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:
"Health Policy Brief: Graduate Medical Education," *Health Affairs*, August 16, 2012.

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