American College of Physicians
Leading Internal Medicine, Improving Lives

February 14, 2020

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Grassley:

On behalf of the American College of Physicians (ACP), I am writing in response to your recent inquiry to Department of Health and Human Services (HHS) Secretary Alex Azar seeking information about Graduate Medical Education (GME) programs. We appreciate your interest in, and oversight of, the federal government's role in funding GME and would like to share ACP's recommendations on financing U.S. graduate medical education. We agree that clear-cut financial transparency and resources focused on rural and underserved areas are necessary. We also feel strongly that the federal government should not only maintain its commitment to GME, but expand support to ensure an adequate supply of primary care physicians, including internal medicine specialists, and physicians in other specialties facing shortages to meet the nation's healthcare workforce needs.

The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. 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.

The Need And Cost of Training Physicians

The training and costs associated with becoming a physician are significant. A student who chooses medicine as a career can expect to spend four years in medical school, followed by three to nine years of graduate medical education (GME), depending on the choice of specialty. 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-funded GME positions at institutions is capped at 1996 levels, which many have 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. A 2019 report from the Association of American Medical Colleges (AAMC) estimates there will be a shortage of 21,100 to 55,200 primary care physicians by 2032. 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.

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.

Sustain and prioritize graduate medical education (GME) funding

In 2016, ACP and the Alliance for Academic Internal Medicine developed a comprehensive proposal, Financing U.S. Graduate Medical Education: A Policy Position Paper of the Alliance for Academic Internal Medicine and the American College of Physicians for GME innovation and reform. In the position paper, we urged Congress: to develop legislation 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; to improve transparency; and to ensure sustainable and broadly supported funding by all payers going forward.

Strategically Lift Caps on GME

ACP recommends that Congress should 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, and 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 with the skills and training needed to care for an aging population with multiple chronic diseases, including training of more internal medicine physician specialists. Internal medicine physicians will be especially needed as the population ages and more patients acquire chronic diseases.

Address Geographic Maldistribution

ACP recommends a thorough assessment of the supply, specialty mix, and distribution of physicians and Medicare GME resources should be used to address shortcomings. Physicians tend to stay and work where they were trained, so Medicare GME dollars should be weighted to favor training programs in rural and underserved areas. Students from rural areas are more likely to practice there than those from urban areas. Weighting or shifting GME dollars to programs in areas where physicians are needed most might lead to an increase in training positions in underserved areas and a change in the distribution of physicians once their training is completed.

Reform GME Financing

Direct GME (DGME) and Indirect Medical Education (IME) should be combined into a single, more functional payment program and the GME financing structure should be broadened 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.

Increase Transparency

Lastly, Congress should 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.

Conclusion

ACP believes that a comprehensive GME financing policy, that fully funds existing and additional residency positions on a prioritized basis, is needed to ensure that the nation has an adequate supply of the types of physicians needed to treat patients, that they enter the workforce with the knowledge and skills required to provide the highest quality care, and that all Americans have access to such care. The nation will not be able to expand access, improve health outcomes, and decrease health care expenditures without a national health care workforce policy and the appropriate direction of funding to achieve these goals. The College also believes the costs of financing GME should be spread across the health care system and that all payers should be required to contribute to a financing pool to support residencies that meet policy goals related to supply, specialty mix, and site of training.

We look forward to working with you as you continue to examine GME and potentially develop legislation in the 116th Congress and stand ready to serve as a resource for you on any matters regarding the physician workforce. If you have any questions or comments about ACP's GME policy recommendations, please contact Brian Buckley at bbuckley@acponline.org.

Sincerely,

Robert M. McLean, MD, FACP
President

Cc: Members, Senate Finance Committee