Graduate Medical Education
Where Do We Go From Here?

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History of GME

- Medicare
  - Provided training of new physicians through GME programs in major teaching hospitals
  - Funding would continue through Medicare "until the community [society at large] undertakes to bear such education cost in some other way."
Despite attempts to broaden support for paying GME, no policy has been implemented.

- In 2007, Medicare provided $8.8 billion of GME funding.
- Private insurers support funding (implicitly) through higher payments for patients.
Private insurers contributed $7.2 billion in support of GME in 2006-2007

- Almost impossible to accurately determine this amount
- Private insurance strongly opposes any mandate to pay a portion of GME expenses
Medicare Payments

- **Direct medical payments (DME)**
  - Cover a share of salary of residents, supervising faculty, and other allowable program expenses

- **Indirect Medical Payments (IME)**
  - Cover the added patient costs associated with training (tests, procedures)
Balanced Budget Act of 1997: capped the number of residency positions

- Predicted oversupply of physicians
- BBA limited slots to the number of residents training in a given teaching hospital as of December 31, 1996
- AMA and AOA advocate for increasing the cap
Resident Numbers

- Approximately 17,000 students graduate from MD schools with an additional 5,000 students by 2015
  - Association of American Medical Colleges (AAMC) recommends increased enrollment in its schools by approximately 30%
- DO graduates will number 4,600 in 2012 with increases every year through 2020
Efforts to Lift the Cap

- Legislation in 111th Congress
  - *Physician Workforce Enhancement Act of 2009/HR 914*
    - Pay new programs an interest-free loan to begin new programs
    - Increase the number of primary care programs, including general surgery
6,500 positions receive no GME support from Medicare

In 2002 there were 98,258 total AMA GME slots

In 2006 there were 104,879, an increase of 6.3%
Family Medicine GME

- Family Medicine Residencies
  (3,262 or 89.1% fill rate)
  - 71.1% were filled by ACGME students in 1997
  - Only 44.2% were ACGME graduates in 2004-2005

- 2008 - total matches in Family Medicine was 2,313
## AOA GME Slots

### 2007-2008 Academic Year
- **OGME total positions** - 9,326
- **OGME positions filled** - 4,934

### Family Practice
- **2005-2006**: 1,691 Positions/500 filled
- **2007-2008**: 1,823 Positions/652 filled
Positions added by the AMA have increased the number of subspecialty fellowship positions

- Simply removing the cap will allow teaching hospitals to continue recent practices, having no meaningful on the number of PGY-1 positions

- **Will also have no impact on overall need of primary care training slots available**
Changes

- Regulation of the mix of generalists and specialists supported by Medicare
  - Clinton Administration
  - Congress
  - Physician Payment Review Commission
Bush administration opposed regulating the composition of the physician workforce

Market forces would solve the problem
Changes

- Obama administration’s support for financing GME?
- Desire to increase primary care, but currently the talk is based on a budget neutral act, which would pull monies from the specialist, causing opposition
MedPAC recommendations

- Upward adjustment of Medicare fees for primary care services
- Initiate pilot projects for the medical home, with the hope it would spur more medical graduates into primary care
AARP expresses concern over the decline of Primary Care

“Primary Care is key to more effective and efficient services, especially for individuals with multiple chronic conditions.”

“We support changes in physician reimbursement that will generate a more appropriate mix of physicians going forward.”
Centers of Medicare and Medicaid

Mark B. McClellan, administrator of the Centers for Medicare and Medicaid Services from 2004-2006

(Need) . . . “broad support for changes that could save money and provide better support for training physicians in innovative approaches to coordinate care, enhance care for disadvantaged populations and develop better models of transitional research.”
Summary

- Policies to encourage more medical school graduates to pursue careers in primary care, that will ultimately focus on financial incentives rather than (as it did 15 years ago) on the creation of a national commission that would allocate residency positions among specialties
Compel policymakers and private stakeholders to acknowledge the value of making primary care the centerpiece of a restructured health care system, as is the case in most other industrialized nations.
References

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