



TESTIMONY

of the

American Medical Association

before the

Institute of Medicine Committee on the Governance and Financing of

Graduate Medical Education

Re: Graduate Medical Education

Presented by: Susan E. Skochelak, MD, MPH

December 19-20, 2012

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Since its founding in 1847, the American Medical Association (AMA) has been dedicated to promoting the art and science of medicine and the betterment of public health. This high purpose has unified America's physicians through 165 years of profound scientific, demographic, economic, technological, and political change. The AMA appreciates the opportunity to testify on behalf of our physician and medical student members before the Institute of Medicine's (IOM) Committee on Governance and Financing of Graduate Medical Education at today's public hearing. As the Committee studies methods for financing graduate medical education (GME) in the United States, we urge you to consider our comments and recommendations below.

The importance of patient care provided by residents and fellows

Residents and fellows learn while providing direct patient care in hospitals and clinics under the direct supervision of a teaching physician. The roles of residents and fellows vary somewhat by graduate year and specialty, with interns generally being responsible for initial patient assessment and laboratory inquiry and more advanced trainees determining courses of action and treatment plans for the patients under the attending physician's supervision. While on duty, residents are the first-line contact for patient care issues and emergencies pertaining to patients on their service. Many types of residents (e.g., surgery, radiology, obstetrics, family medicine) also learn and perform surgical procedures under supervision and are engaged in the pre and postoperative medical and surgical care of their patients. Residents spend a substantial amount of time teaching medical students, and fellows teach residents and medical students.

Formal GME training occurs in only a small fraction (about 6 percent) of our nation's hospitals; however, residents and fellows are directly involved in providing a disproportionate amount of complex and acute care to the general population as well as to a large number of medically underserved, indigent, and elderly patients.¹

Care provided by residents and fellows in U.S. academic hospitals² includes:

- 20% or more of all hospital care in the country
- 28% of all Medicaid hospitalizations
- 40% of all hospital charity care, amounting to around \$8.4 billion annually
- 40% of high-acuity patient transfers
- 62% of pediatric ICU care
- 80% of level I trauma center care

Residency and fellowship training programs have affiliations not only with large university teaching hospitals, but also with surrounding community and county/state hospitals, satellite clinics in neighboring towns, and often with Veterans Administration (VA) sites as well.^{1,3,4} In many cases, such affiliations provide desperately needed financial resources and medical expertise to these facilities.⁵ These non-university hospitals that train resident/fellow physicians cater to a large proportion of the uninsured, Medicaid, and indigent populations.^{6,7} Teaching hospitals are also more likely to do community outreach. For example, 89 percent of teaching hospitals offer ambulatory services to HIV/AIDS patients, compared to 16 percent of nonteaching hospitals. Patients in these facilities often are unable to access preventive care services; therefore, affiliation with and funding from residency programs contribute to a healthier community at-large.⁸

The case for stable if not increased funding for GME

Many authorities agree that by 2025 the U.S. will face a shortage of physicians to meet the needs of a growing and aging population. Furthermore, the demand for physician services will increase as approximately 32 million Americans will demand more health care services with the implementation of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). While new U.S. allopathic and osteopathic medical schools are opening and many medical schools are expanding their enrollments to meet the need for more physicians, core residency training programs are experiencing minimal growth due to limited federal funding. This means that the growth of medical school graduates is having a minimal impact on the number of physicians entering practice.

The training of resident physicians is heavily dependent upon funding through the Medicare system. Medicare has historically paid for its share of the costs of training and the highly sophisticated health services provided by teaching hospitals. The cost to train residents averages over \$100,000/year/resident.⁹ While Medicare pays over \$9.5 billion annually to support GME, the funding does not come close to the cost of maintaining teaching programs (approximately \$27 billion).⁹ The 1997 Balanced Budget Act capped the number of Medicare-funded GME positions at 1996 levels for almost all teaching hospitals. The cap has made it impossible for institutions to expand or create new core GME programs. As a result, it is becoming increasingly competitive for graduates of U.S. medical and osteopathic schools to enter a core residency program in the U.S.

The ACA-authorized redistribution of some unused GME residency slots has provided a few new residency positions in primary care and general surgery, but these changes will not be enough to build an appropriately sized and fully trained medical workforce and address the shortages that have been identified by 33 states and 22 physician specialty organizations.¹⁰ Given the long pipeline for physician training (at least seven years post-college), combined with the years required to build and accredit new residency programs, expansion of GME has to be approached with some urgency. In the midst of our country's severe physician shortage, the situation will only deteriorate further because of the high number of physicians who are expected to retire, 32 million uninsured patients currently entering the health care system, increasing chronic illnesses such as diabetes and cardiovascular disease, and an aging population. Several federal bills were introduced in the 112th Congress that included support for increasing GME slots by 15 percent in order to address physician shortages.¹¹ **The AMA recommends not only preserving the current level of federal funding for GME and ensuring adequate, stable funding for GME, but increasing GME funding to support, at a minimum, a 15 percent increase in GME slots to address physician shortages in undersupplied specialties and underserved areas.**

Medicare GME payment reform

With a number of reforms for Medicare financing being proposed, the potential impact on GME funding and distribution remains unclear. GME and other non-insurance programs in Medicare have been funded through various adjustments in Medicare fee-for-service payments to hospitals. The AMA is concerned that a severe reduction or even elimination of the federal government's support for GME could lead not only to cost shifting of these services to local and state governments, and other potential funding sources, but also to substantial reductions in medical training opportunities, affecting patients, hospitals, and the health system at large. If faced with steep cuts, teaching hospitals might also be inclined to cut the vital services they currently provide at times uncompensated, including community outreach, research, and complex and acute care. While the AMA acknowledges that new models of funding care must be assessed in this fiscal environment, we also want to point out that there are many complicated issues surrounding GME funding that need to be addressed as Medicare evolves. **The AMA appreciates the critical importance of all of these issues, and we stand ready to work with all stakeholders to explore proposals for GME governance and financing.**

Ensuring adequate funding for Title VII, National Health Service Corps (NHSC), and Children's Hospitals GME Programs

In this budgetary climate, ensuring adequate funding levels for Title VII, NHSC, and Children's Hospitals GME programs will be challenging as well, but these programs are also vital links for patient access to care and provide training and debt relief opportunities for physicians.

Title VII Health Professions programs work to improve the diversity, distribution, and supply of the health professions workforce, with an emphasis on primary care and interdisciplinary training. The NHSC improves access to health care for the growing numbers of underserved Americans, provides incentives for practitioners to enter primary care, reduces the financial burden that the cost of health professions education places on new practitioners, and helps ensure access to health professions education for students from all backgrounds. The Health Resources and Services Administration's (HRSA) Children's Hospitals Graduate Medical Education (CHGME) program provides critical support for freestanding children's hospitals. Federal funding is critical for supporting this vital training program for pediatricians and pediatric subspecialists in children's hospitals, given their lack of financial support from Medicare. Further, many pediatric specialties are among those chronically in short supply. **The AMA also recommends adequate funding for these vital programs to improve the diversity, distribution, and supply of the health professions workforce.**

International Medical Graduates

It is important to note that international graduates comprise almost 27 percent of residents and fellows in the U.S. and 25 percent of all practicing physicians. Since state licensing boards do not recognize other countries' medical licenses or GME programs, all international graduates (no matter how well trained they are or how long they have been in practice in their home countries) must enter the U.S. physician workforce pipeline through GME programs. All international graduates follow the same process as U.S. medical graduates to be considered for GME program acceptance. First, they must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) before they can apply to GME programs. ECFMG-certification indicates that the certificate holder has been deemed ready to start GME. In addition to becoming ECFMG-certified, thousands of international graduates conduct medical research, teach, obtain other advanced degrees, participate in observerships, volunteer at free clinics, and seek additional

clinical experiences in order to increase their chances to match into a GME program. While thousands of international graduates are in GME programs, there are several thousand more qualified international graduates (many of whom are permanent U.S. residents and U.S. citizen international graduates) who continue to wait to be accepted into a residency program.

It is also important to recognize that international graduates provide much needed patient care since many of them, enter primary care specialties and serve in underserved and shortage areas, including intercity and rural areas.¹² International graduates who are on a J-1 visa during their GME training, may apply for a J-1 visa waiver, which will allow them to stay in the U.S. after their GME training, if they agree to work in an underserved or shortage area. Since the development of the J-1 visa waiver program in 1994, over 9,000 international graduates have been granted waivers. Without these international graduates, thousands of patients would be without a physician in their communities. International graduates play a critical role in caring for the country's neediest patients. Federal legislation was signed into law this year that extends for three years (through September 2015) the Conrad State 30 J-1 Visa Waiver Program, a vital program for placing international graduates in communities that face health care access challenges. **We support the permanent reauthorization and expansion of the Conrad State 30 J-1 Visa Waiver Program.**

Medical student debt

In addition to GME factors discussed above, a driver for workforce, specialty, and geographic location choices is medical student debt.¹³ We must address the issue of medical student debt as it currently impedes the development of a socioeconomically diverse physician workforce and influences the choice of specialty and practice location. Physicians carry a median debt of \$160,000 (if they attended a public medical school) or \$190,000 (if attending a private institution)¹⁴ when they enter GME, and interest continually accrues on many of the loans borrowed to finance medical education. Residents and fellows must either begin repaying or forbear loans while in training. Depending upon loan repayment or forbearance options selected during residency, total paybacks after training when factoring in accrued interest can approach \$500,000, and monthly payments often range between \$1,500-\$2,100 for a 30-year repayment period.¹⁴ **Stable, low interest rates on college and graduate student loans and loan repayment and forgiveness programs to ease medical student debt burdens will be important issues to be addressed during the reauthorization of the Higher Education Act next year.**

AMA efforts in education across the continuum

As 2013 approaches, the AMA has set forth a multi-year strategy, defined during a period in which the state and future of health care appear particularly unsettled.¹⁵ The AMA outlined a long-range strategic plan that focuses on three core areas that include improving patients health outcomes while reducing health care costs, accelerating change in medical education to align physician training and education with the future needs of our health care system, and enhancing professional satisfaction and practice sustainability by helping physicians navigate delivery and payment models.

The AMA plans to accelerate change in undergraduate medical education in part to align with the changes that are occurring with the restructuring of the GME accreditation system. In January 2013, the AMA will release a request for proposals to U.S. medical schools to establish a collaborative with select medical schools and health care systems in order to develop innovations supporting new, flexible, and outcomes-based education across the continuum. In addition, the

AMA will convene a consortium of medical schools and additional partners to evaluate and promote adoption of successful innovations.

Summary

As the IOM Committee on Governance and Financing of Graduate Medical Education works toward a proposal to align GME financing with the public's health care workforce needs, we urge you to consider the long-term impact of cutting Medicare's investment in physician training versus the short-term "savings" that may be obtained. Proposed changes in GME should be carefully crafted to avoid exacerbating projected shortages of physicians across all specialties, including primary care.¹⁶

New and existing medical schools have taken the first step in addressing the shortage by expanding the overall number of medical students enrolled in their respective institutions. This contributes to a larger pool of future physicians, but is only the first step. The next step is to assure a sufficient number of residency training programs. Unfortunately, Medicare's current cap on financial support for GME prevents teaching hospitals from expanding the number of training positions and often prevents new hospitals from establishing teaching programs.

Now is the time for our nation to invest in physician training programs, not reduce them. Cuts to Medicare GME financing likely will exacerbate the physician shortage at a time when an estimated 10,000 seniors enter the Medicare program each day, and with one in three practicing physicians planning to retire by 2020.¹⁷ Ensuring access for Medicare beneficiaries requires long-term and rational physician payment reforms, as well as an adequate supply of physicians to care for an aging nation.

The AMA is actively working to strategically reshape and accelerate change in medical education in the U.S. and advocating to reduce the debt incurred by medical students. However, the pending GME bottleneck hampers these initiatives as well as other improvements underway to transform medical education across all phases of physician training. If the GME cap is not lifted, hundreds of U.S. medical students will graduate with significantly limited opportunities to finish their training and become practicing physicians, and the growing number of U.S. citizens and non-citizens graduating from foreign medical schools will not be able to train in the U.S. Ultimately, the increase in medical school enrollment will have minimal impact on the physician shortage unless the legislative and structural challenges being faced by GME are addressed and a secure, rational, and fiscally sound funding model is in place.

Conclusion

The AMA appreciates this opportunity to provide input to the IOM Committee, and we offer our assistance to the Committee as it develops its recommendations to the Secretary of Health and Human Services. **The AMA stands ready to work with all stakeholders to explore proposals for GME governance and financing.**

References:

1. Weissman JS, Campbell EG, Gokhale M, Blumenthal D. Residents' preferences and preparation for caring for underserved populations. *J Urban Health* 2001; 78(3):535-49.
2. What roles do teaching hospitals fulfill? Teachhospfacts1.pdf. Association of American Medical Colleges. Available at: www.aamc.org (accessed 9-30-2012).
3. Hillman AL, Goldfarb N, Eisenberg JM, Kelley MA. An academic medical center's experience with mandatory managed care for Medicaid recipients. *Acad Med* 1991; 66(3):134-8.
4. Moy E, Valente E Jr, Levin RJ, Griner PF. Academic medical centers and the care of underserved populations. *Acad Med* 1996; 71(12):1370-7.
5. Sheffield JV, Young A, Goldstein EA, Logerfo JP. The public hospital mission at Seattle's Harborview Medical Center: high-quality care for the underserved and excellence in medical education. *Acad Med* 2006; 81(10):886-90.
6. Moy E, Valente E Jr, Levin RJ, Bhak KJ, Griner PF. The volume and mix of inpatient services provided by academic medical centers. *Acad Med* 1996; 71(10):1116-22.
7. Fishman LE. What types of hospitals form the safety net? *Health Aff* (Millwood). 1997; 16(4):215-22.
8. Rich EC, Liebow M, Srinivasan M, Prish D, Wolliscroft JO, Fein O, Blaser R. Medicare financing of graduate medical education. *J Gen Intern Med* 2002; 17(4):283-92.
9. What Does Medicare Have to Do with Graduate Medical Education? Association of American Medical Colleges. Available at: www.aamc.org/download/253380/data/medicare-gme.pdf (accessed 12-5-12).
10. Recent Studies and Reports on Physician Shortages in the US. Center for Workforce Studies, Association of American Medical Colleges. October 2012.
11. S. 1627 "The Resident Physician Shortage Reduction Act;" H.R. 6352 "The Resident Physician Shortage Reduction and Graduate Medical Education Accountability and Transparency Act;" and H.R. 6562 "The Resident Physician Shortage Reduction Act."
12. Mick S. The safety-net role of international medical graduates. *Health Affairs*. 1999;16:141-150.
13. Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student & Resident Choices? The Robert Graham Center: Policy Studies in Family Medicine and Primary Care. Josiah Macy, Jr. Foundation. March 2, 2009. Available at: www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2009/rgc-mo-specialty-geographic.Par.0001.File.tmp/Specialty-geography-compressed.pdf (accessed 12-5-12).
14. Medical Student Education: Costs, Debt, and Loan Repayment Facts. 2011. Association of American Medical Colleges. Available at www.aamc.org/download/152968/data/debtfactcard.pdf (accessed 11-20-12).
15. Accelerating Change in Medical Education. American Medical Association. Available at: www.ama-assn.org/ama/pub/about-ama/strategic-focus/accelerating-change-in-medical-education.page (accessed 12-4-12).
16. Fixing the Doctor Shortage. Association of American Medical Colleges. Available at: www.aamc.org/initiatives/fixdocshortage/ (accessed 11-20-12).
17. Physician Shortages to Worsen Without Increases in Residency Training. Association of American Medical Colleges. Available at: www.aamc.org/download/150584/data/physician_shortages_factsheet (accessed 12-5-12).