

Position Statement

The Financing of Graduate Medical Education

This Position Statement was developed as an educational tool based on the opinion of the authors. It is not a product of a systematic review. Readers are encouraged to consider the information presented and reach their own conclusions.

The health and welfare of patients are linked to the knowledge and skills physicians develop in the years immediately following graduation from medical school. During this typically three to seven year period of graduate medical training, young physicians ("residents") participate in the care of patients and study in supervised educational programs. The satisfactory completion of "Graduate Medical Education" (GME) in one of these approved programs is a prerequisite to achieving board certification in a medical or surgical specialty. Medical school graduates are physicians but cannot receive an unrestricted medical license to practice their profession without graduate medical education.

The AAOS recognizes that formal graduate medical education following medical school is necessary for young doctors to master the knowledge and skills necessary to diagnose and treat patients.

In providing graduate medical education, teaching institutions incur a variety of expenses beyond those attributable to patient care.¹ These include the direct costs of educating residents, such as salaries and benefits for residents, faculty, and other support staff as well as the costs of institutional space devoted to clinical training.² Further, indirect costs of training residents include the additional staff time and other resources needed to involve residents in patient care.²⁻³ In addition, teaching hospitals are often the vanguard of medical science attracting more complex and ill patients with concomitantly higher treatment costs.⁴

Financing Graduate Medical Education

GME is primarily supported through patient care revenues. Traditionally, most payers have implicitly financed graduate medical education because their costs are included in teaching hospital charges. Medicare, which is the largest single funding source, typically provides teaching hospitals with higher prospective payments to help cover the indirect costs of graduate medical education.⁶ Additionally, Medicare makes separate payments to teaching hospitals to help cover the direct costs of resident graduate medical education. These payments are meant to reimburse hospitals for Medicare's portion of these expenses.

Rising costs of providing health care have outpaced the mechanisms in place to subsidize graduate medical education. Further, some payers now reimburse teaching hospitals at the same rates that are paid to non-teaching hospitals.⁷ In addition, federal policymakers in recent years have implemented limits on Medicare financing of graduate medical education, and are currently considering further reductions.^{6,8} This would be a detrimental policy that could potentially deter students from entering a career in medicine or orthopaedic surgery.

Another potential concern with regard to private and public sector funding is the evolution of different payment models including bundling and value-based "pay for performance." Although these payment models may be designed to improve quality while decreasing cost, the financing of graduate medical education cannot be threatened by performance measures such as cost, complications and readmissions.⁹

The American Academy of Orthopaedic Surgeons (AAOS) believes that graduate medical education is vital to the well-being of our health care system and must be maintained through strong financial support. Rising costs of providing patient care and diminishing funding sources for the additional financial burden of specialty graduate medical education compromises the ability of institutions to provide adequate physician training.

Graduate medical education is an essential component in the training of our nation's future physicians. It is a service to our society which needs and deserves strong financial support from both the public and private sectors. Therefore, teaching institutions should be fully reimbursed by all payers for the reasonable costs of their graduate medical education programs. Since graduate medical education is a public good, Medicare financing should not be decreased further unless other sources of funding are more fully developed. All payers, public and private, share the benefit of physician graduate medical education. Likewise, all payers should share in the stable financial support of graduate medical education.

Addressing Physician Workforce through GME financing

The American Association of Medical Colleges estimates that by 2025, there will be an unmet need for around 131,000 doctors. Approximately 65,000 of these physicians will be specialists such as orthopaedists. Federal policymakers have been considering Medicare payment policies which encourage teaching hospitals to create more primary care residency positions. Consequently, these proposals would adversely affect financing for surgical specialist residency programs.²

Data from the National Resident Matching Program indicate that there are an adequate number of available primary care residency positions, but a significant number of these positions are not filled by US medical school graduates. In 2014, there were 26,678 post-graduate year (PGY)-1 residency positions available. This represents a 4,000 spot increase over the last 5 years, the majority of which have been in primary care residencies including Internal Medicine (IM) and Family Practice (FP). The IM and FP programs filled 99.1% and 95.8% of their spots respectively, although only 48.5% and 45% of the slots were filled with U.S. medical school graduates and the others with foreign medical graduates. This data shows that the failure of medical students to choose primary care residency training is based on personal and professional factors which transcend the educational financing process. A greater and more pressing issue is that the number of Medicare funded resident positions was capped based on resident levels in 1996. Therefore, a bottleneck is developing in medical training in which medical schools are increasing the number of students obtaining medical degrees, but they are not matched with a respective increase in residency training positions. In 2013 the United States graduated 20,164 medical students versus 26,504 who matriculated. In that same year 26,392 PGY-1 residency spots were available. One can see that without significant increases in residency spots, the domestic production of medical school graduates will outstrip the number of GME positions available.

The AAOS believes that the manipulation of graduate medical education financing as a means to implement national physician manpower policies is ineffective. The AAOS also supports these Association of American Medical Colleges (AAMC) policies:

- 1. The number of federally supported GME training positions should be increased to meet patient needs.***
- 2. Attempts to increase physicians in targeted specialties by reducing training of other specialists will impede access to care.***
- 3. Efficient health care delivery models must be developed.***

The AAOS recommends that physician manpower policies be developed through a careful and deliberative process that takes into account the factors that influence how physicians choose their specialties. Furthermore, policies on physician manpower should be designed in ways that do not threaten the quality of graduate medical education in specialties which are predicted to face shortages. Attempts to increase physicians in targeted specialties by reducing training in other specialties will impede access to care.

Additionally, the AAOS firmly believes that all residency slots across medical and dental professions should be treated with equity. The Balanced Budget Act of 1997 limited the number of allopathic and osteopathic medical residents that would be counted for purposes of calculating Medicare indirect medical education (IME) and direct graduate medical education (DGME) reimbursement. These resident limits excluded podiatry.

The AAOS believes that preferential funding creates unintended asymmetries and real workforce implications. The unlimited number of funded podiatry training positions serves as an advantage to podiatrists, who are more limited than orthopaedic surgeons in the type of musculoskeletal services they can provide. Exclusions to the resident limits should be eliminated.

Direct medical education (DME) payments are made through a hospital-specific "per-resident payment" that varies widely across the United States based on the training cost for each individual hospital negotiated in fiscal year 1983, adjusted for inflation. In 2011, only 44 states funded GME through their Medicaid funds, while nine others had considered ending GME Medicaid funding. One study that analyzed Medicare cost reports from teaching hospitals found several large state-level differences, for instance an average payment per resident of \$63,811 in Louisiana versus \$155,135 in Connecticut.¹⁰

The AAOS believes that quality graduate medical education and its funding are of critical importance to ensure the future health of Americans and should be supported by all stakeholders. While recognizing the importance of models which improve the quality and decrease the cost of healthcare, every attempt must be made by both public and private sectors to protect specialty and primary care graduate medical funding

References:

1. Mechanic R, Coleman K, Dobson A: Teaching hospital costs: implications for academic missions in a competitive market. *JAMA*, 1998; 280:1015-1019.
2. Covey AS, Friedlaender GE: Financing graduate medical education: sorting out the Ccnfusion. *J Bone Joint Surg Am*, 2003; 85:1594-1604.
3. Schott NJ, Emerick TD, Metro DG, Sakai T: The cost of resident scholarly activity and its effect on resident clinical experience. *Anesth Analg*, 2013; 117:1211-1216.
4. Fryer GE, Green LA, Dovey S, Phillips RL: Direct graduate medical education payments to teaching hospitals by Medicare: unexplained variation and public policy contradictions. *Acad Med*, 2001; 76:439-445.
5. Novitsky YW, Sing RF, Kercher KW, Griffo ML, Matthews BD, Heniford BT: Prospective, blinded evaluation of accuracy of operative reports dictated by surgical residents. *Am Surg*, 2005; 71:627-631; discussion 631-632.
6. Rye B: Assessing the Impact of Potential Cuts in Medicare Doctor-Training Subsidies. Bloomberg Government Study, 2012.
7. Gottlieb S, Einhorn TA: Managed care: form, function, and evolution. *J Bone Joint Surg Am*, 1997; 79:125-136.
8. Davis PH: The Effects of the Balanced Budget Act of 1997 on Graduate Medical Education. Council on Graduate Medical Education Resource Paper, 2000.

9. Froimson MI, Rana A, White RE, et al: Bundled payments for care improvement initiative: the next evolution of payment formulations: AAHKS Bundled Payment Task Force. *J Arthroplasty*, 2013; 28:157-165.
10. Mullan F, Chen C, Steinmetz E: The geography of graduate medical education: imbalances signal need for distribution policies. *Health Affairs*, 2013 Nov;32(11):1914-21.

©May 1992 American Association of Orthopaedic Surgeons® . Reviewed December 2007 and revised June 2015.

This material may not be modified without the express written permission of the American Association of Orthopaedic Surgeons.

Position Statement 1109

For additional information, contact the Public Relations Department at 847-384-4036.