

Limit direct graduate medical education (DGME) and indirect medical education (IME) payments to the training for first-certificate residency programs.

Today, there are more than 114,000 resident physicians training in more than 150 specialties and subspecialties. Even though there are more than 150 unique disciplines in medicine, all physicians initially train in one of 25 primary specialties—often referred to as “first-certificate programs” or the “initial residency period.” These programs are foundational to other subspecialties, meaning that a physician seeking a subspecialty must first complete training in one of the first-certificate programs (sidebar).

The federal government, through the Medicare program, finances training in first-certificate residency programs and fellowships. Under current law, fellowship positions are funded at 50% for direct graduate medical education (DGME) and 100% for indirect medical education (IME). While there is value in training physicians in subspecialties, the concept of the government financing such training is what we are questioning. Because physicians who have completed an initial residency are eligible for board certification, they are, in practicality, allowed to practice medicine and bill for their services—which raises the question of why they require financial assistance with the cost of their training.

Trends in graduate medical education (GME) support the self-sustainability of fellowship programs. Specifically, we know that since 1997, new fellowship positions have been created that do not receive financial support from Medicare, clearly demonstrating that the revenue generated is sufficient to support these positions, thus eliminating the need for federal support.

To this end, the AAFP recommends that Medicare DGME and IME funding be limited to those full-time equivalent positions in first-certificate residency programs. We further recommend that all funding currently dedicated to fellowship training positions be repurposed for first-certificate residency positions, distributed on an annual basis, consistent with our “Increasing Accountability” policy recommendations. Implementation of this recommendation would result in more than 7,500 new first-certificate training positions.

FIRST-CERTIFICATE RESIDENCY PROGRAMS

Allergy & Immunology
Anesthesiology
Colon & Rectal Surgery
Dermatology
Emergency Medicine
Family Medicine
Internal Medicine
Medical Genetics
Neurological Surgery
Neurology
Nuclear Medicine
Obstetrics & Gynecology
Ophthalmology
Orthopaedic Surgery
Otolaryngology
Pathology
Pediatrics
Physical Medicine & Rehabilitation
Plastic Surgery
Preventive Medicine
Psychiatry
Radiology
Surgery
Thoracic Surgery
Urology

There are an estimated 9,333 approved and funded fellowship positions in the United States. Elimination of Medicare DGME and IME funding for fellowship positions would allow for the creation of approximately 7,777 new first-certificate training positions.

Align financial resources with population health care needs through a 0.25% reduction in IME payments—from the current 5.5% to 5.25%—and allocate these resources to support innovation in graduate medical education.

Under current law, all Medicare GME funding is directly associated with hospitals and services provided in hospitals. This funding mechanism was established more than 50 years ago, when hospitals were the center of our nation's health care delivery system and medical education system. Today, an increasing percentage of health care is provided in an outpatient or ambulatory setting, raising questions about why our national financial support of GME would remain solely tied to hospitals.

The AAFP believes that our national investment in GME should be more closely aligned with how we actually deliver care versus an historic model that was created half a century ago. To this end, we recommend that Medicare align its financial resources with the actual health care needs of the population through a 0.25% reduction in IME payments—from the current 5.5% to 5.25%—and allocate these resources to support innovation in community-based GME programs.

This policy would establish a permanent funding source for community-based GME and align a small portion of our national investment in GME with those settings in which a majority of care is actually provided.

CURRENT GME SPENDING = \$9.5 BILLION
CURRENT DGME SPENDING = \$3 BILLION
CURRENT IME SPENDING = \$6.5 BILLION
CURRENT IME RATE = 5.5%

By creating a “redirect” financing mechanism of existing GME funds, innovative GME programs could expand to more states and communities, and the Affordable Care Act-created National Health Care Workforce Commission could finally be funded. Reducing the IME rate to 5.25% would create an annual delta of approximately \$300 million that could be directed toward community-based primary care training.

Fund the National Health Care Workforce Commission

The Patient Protection and Affordable Care Act created the National Health Care Workforce Commission, a 15-member panel charged with reviewing current and projected health care workforce supply and demand, and making recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies.

Despite being established through statute, Congress has not allocated funding for the Commission. The AAFP encourages Congress to fund the National Health Care Workforce Commission at a level that allows it to meet its statutory mandate.