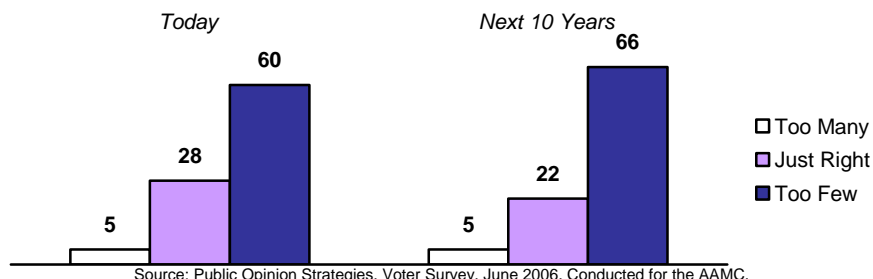




## Lifting the Cap on Medicare-funded Residency Slots Reduces the Shortage of Physicians

Support legislation that would allow the Secretary of Health and Human Services (HHS) to increase the cap on the number of Medicare-supported residency training positions at teaching hospitals in states with shortages of resident physicians.

### Voters Believe There Are Too Few U.S. Doctors



**Background:** Currently, the Council on Graduate Medical Education (COGME), which was authorized by Congress in 1986, projects a shortage of 85,000 physicians by 2020<sup>1</sup>, and a 2008 report from the Association of American Medical Colleges (AAMC) estimates a shortage of at least 124,000 physicians by 2025<sup>2</sup>. The Balanced Budget Act (BBA) in 1997 capped the number of residents each teaching hospital could claim for reimbursement under Medicare. Medicare does not generally reimburse teaching hospitals for training residents if the number exceeds the capped number of residency slots.

**Recommendations:** COGME recommends removing the current cap on residency slots and increasing the number of funded slots by 15%<sup>3</sup>. Additionally, based on recommendations made by the AAMC to increase medical school class size, a peer-reviewed study published in the *Journal of the American Medical Association* (JAMA) projects an additional 21,000 residency spots will be necessary within the next decade<sup>4</sup>. The study notes that an increase in U.S. medical school graduates will not lead to a significant increase in the number of practicing physicians, and that the current cap on Medicare-funded residency slots may play a role in decreasing the number of physicians training in primary care specialties.

#### The American Medical Association recommends:

- lifting the cap on Medicare-funded residency slots;
- fully funding graduate medical education (GME) and preserving Medicare and Medicaid funding of residency slots;
- investigating additional sources of GME funding;
- removing the regulatory barriers that apply GME funding to limited training sites; and
- establishing medical education commissions that include a wide variety of stakeholders to determine and make recommendations on geographic and specialty distribution physician workforce needs.

**Benefits:** The Medicare Payment Advisory Commission (MedPAC) states that payments for GME should be viewed as payments for patient care rather than training<sup>5</sup>. In addition, increasing the number of residency slots directly contributes to the number of physicians in the workforce, which helps to solve the physician shortage. A growing patient population will directly benefit from an increase in the number of practicing physicians.

<sup>1</sup> *Sixteenth Report: Physician Workforce Policy Guidelines for the United States, 2000-2020* (January 2005). COGME (<http://www.cogme.gov/pubs.htm>). Accessed February 3, 2009.

<sup>2</sup> *The Complexities of Physician Supply and Demand: Projections through 2025, November 2008* (November 2008). AAMC ([https://services.aamc.org/Publications/showfile.cfm?file=version122.pdf&prd\\_id=244&prv\\_id=299&pdf\\_id=122](https://services.aamc.org/Publications/showfile.cfm?file=version122.pdf&prd_id=244&prv_id=299&pdf_id=122)). Accessed February 3, 2009.

<sup>3</sup> *Nineteenth Report: Enhancing Flexibility in Graduate Medical Education*. (September 2007). COGME (<http://www.cogme.gov/pubs.htm>). Accessed February 3, 2009.

<sup>4</sup> Salsberg E, Rockey PH, Rivers KL, et al. US Residency Training Before and After the 1997 Balanced Budget Act. *JAMA*. 2008;300(10):1174-1180.

<sup>5</sup> *Rethinking Medicare* (Aug. 1999). MedPAC (<http://www.aamc.org/advocacy/teachhosp/medpac/rethinkingmedicare.pdf>). Accessed Feb. 3, 2009.