AAFP

# Graduate Medical Education

## AAFP Position

To increase the number of family medicine graduates in the U.S., the American Academy of Family Physicians (AAFP) is committed to removing significant barriers stifling the growth in family medicine specialty choice among U.S. medical graduates. AAFP policy supports consistent funding for graduate medical education (GME) for family medicine to ensure new positions are allocated to address rural and urban imbalances, reduce physician shortages, and focus on medically underserved areas, including funding for programs like the federal Teaching Health Center GME (THCGME) program.

## What is Graduate Medical Education and How is it Financed?

**Graduate medical education** refers to the post medical school graduation period of training, including internships, residencies, and fellowships, which allopathic and osteopathic physicians (MDs and DOs) pursue in accredited programs.

- The Accreditation Council for Graduate Medical Education accredits sponsoring institutions, such as teaching hospitals, teaching health centers, and residency and fellowship programs, which meet certain standards for training leading to licensure and board certification.
- These programs vary in medical specialty and size, ranging from small outpatient clinics to large urban teaching hospitals.

**$16B**

The federal government spends around $16 billion on GME ($16.2 billion in FY 2020) annually through **Medicare, Medicaid, the Departments of Defense and Veterans Affairs, and the Children's Hospital and Teaching Health Center GME programs**.

**$9.5B**

**Medicare**, the single largest payer, spending about $9.5 billion annually, **uses a complex payment formula which includes both direct GME payments and indirect medical education payments** based in part on the number of Medicare patients and residents in training.

## Primary Care Physician Shortage

The U.S. faces a critical family physician workforce shortage, compounded by decades of neglect, misalignment of priorities and resources in medical education, and the inherent financial interest and competition within the health care industry. While the current system excels at educating skilled physicians and physician researchers, **the primary care physician shortage prevents the U.S. from taking advantage of the better outcomes and lower per capita costs associated with robust primary care systems.** The USC-Brookings Schaeffer Initiative for Health Policy recognized that Medicare GME was not addressing the primary care physician shortage and called for a significant overhaul of the system. Primary care is also the only health care component where an increased supply is associated with better population health and more equitable outcomes.

**48,000**

According to the Association of American Medical Colleges, the U.S. will see a shortage of up to 48,000 primary care physicians by 2034 as demand continues to exceed supply.

The current primary care physician shortage is driven by several factors, including an increase in the number of people who have health insurance, population growth, and aging.

**Fortunately, interest in family medicine has been climbing since 2008, per the National Residency Matching Program (NRMP), or "Match," results.**

In 2023, a record **4,530** medical students and graduates matched to family medicine residency programs – 58 more than in 2021.

Despite this improvement, **neither the current production of family medicine residents nor the number of available residency positions are adequate** to meet existing and future primary care workforce needs, which remain far short of a national goal of 25 percent of all medical school graduates pursuing family medicine by 2030.

**Further action is needed.**

## Teaching Health Center Graduate Medical Education (THCGME) Program

**The THCGME program is an important initiative that addresses the primary care physician shortage by providing federal funding to community-based health clinics.** Grantees are often located in areas where recruiting medical professionals can be difficult. Individuals served by THCGME residents tend to be geographically isolated and economically and medically underserved.

According to federal government data, THCGME graduates are more likely to continue practicing primary care medicine and serving in medically underserved communities than those in Medicare GME-supported programs.

**1,730**

The THCGME program was first authorized by the Affordable Care Act in 2010 and has trained more than 1,730 primary care physicians and dentists – **63 percent of whom are family physicians.**

**38**

During the 2021-2022 academic year, THCs supported 38 family medicine residency programs.

Of the residents who completed THC programs, **34% reported disadvantaged and/or rural backgrounds** and **20% comprised underrepresented minorities.**

### Funding

THGME funding was slated to end in 2023. Legislation to permanently reauthorize and expand the program, the Doctors of Community (DOC) Act**, is strongly supported by the AAFP**.

However, in May 2023, **the House and Energy Commerce Committee voted unanimously to pass** legislation **that includes a 6-year reauthorization of the THCGME program and increased funding**, as well as reauthorization and increased funding for Community Health Centers and the National Health Service Corps.

## State Policy Options

### Medicaid GME Funding

- After Medicare, Medicaid is the second largest source of funding for GME.
- Medicaid GME payments receive a federal match, a strong incentive for states to appropriate Medicaid GME funding.
- **Unlike Medicare GME funding, states have significant flexibility in using Medicaid GME funds**, yet states are not utilizing this flexibility to direct funding to community-based health workforce training programs or primary care specialties.
- As of 2018, 42 states and the District of Columbia provided GME payments under their Medicaid programs; however, like Medicare GME dollars, most of these funds went to urban teaching hospitals.

### Establishment and Funding of Workforce Programs

- In addition to slots funded by federal programs, states may fund additional GME slots as a strategy for workforce development and physician retention.
- In 2020, **47.6 percent of physicians were active in the state where they completed their most recent GME**, indicating a significant return on investment for the state in maintaining adequate health care access.

#### California

**California is one of the few states that does not fund GME through its Medicaid program.** In its place, initiatives established by the Song-Brown Health Care Workforce Training Act program encourage universities and primary care professionals to provide health care in medically underserved areas and provide financial support to family medicine and other primary care programs in California. In 2016, California's state budget included $100 million over three years in new funding for the Song-Brown Program, the largest GME appropriation in California's history. In 2022, the state committed an additional $30 million allocated over three years to the program for primary care GME programs.

### State Investment in TCHGMEs

- Realizing the importance of teaching health centers and trying to provide consistent funding, some states have begun to propose legislation to include funding for teaching health centers in their budgets.
- For example, Massachusetts considered legislation in 2021 which would establish a primary care and family medicine residency grant program to finance the training of primary care providers and family physicians in the THC setting.
- **States can use Medicaid funding to support the start-up and ongoing support of THCs.** In 2021, New Mexico used Medicaid funding to provide federally qualified health centers and total health centers with Medicaid GME funding to support community-based residency training.