United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

October 17, 2019

VIA ELECTRONIC TRANSMISSION

The Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Ave SW
Washington, D.C. 20201

Dear Secretary Azar:

Medicare applies a statutory formula to provide more than $15 billion in Graduate Medical Education (GME) subsidies to hospitals in an effort to accomplish two things: 1) pay the salary of residents (Direct GME); and 2) compensate hospitals for the indirect costs of operating residency programs (Indirect GME).[1] According to the non-partisan Medicare Payment Advisory Commission's (MedPAC) calculations, the indirect costs of operating a residency program are not nearly as high as once thought, and Medicare is likely paying hospitals nearly twice the amount a residency program actually requires.[2] An even lower estimate was published by the Center for Medicare and Medicaid Services (CMS) in a 2011 report.[3] As stewards of taxpayer dollars, Congress must ensure that this expensive program is free of waste and functions as intended.[4]

Most doctors who graduate from medical school in the United States pursue additional training in a specialty through a residency program to become board certified.[5] This three to seven year hands-on experience allows medical residents to work with patients in a high-stress hospital

[1] *See* Marco A. Villagrana, *Medicare Graduate Medical Education Payments: An Overview*, Medpac.gov (2019), *available at* https://fas.org/sgp/crs/misc/IF10960.pdf.
[2] MedPAC, *Medical education in the United States: Supporting long-term delivery system reforms: Chapter 1* 13, Medpac.gov (2009), *available at* http://www.medpac.gov/docs/default-source/reports/Jun09_Ch01.pdf?sfvrsn=0.
[3] *See* Nguyen Xuan Nguyen & Steven H. Sheingold, *Indirect Medical Education and Disproportionate Share Adjustments to Medicare Inpatient Payment Rates*, U.S. Dep't of Health and Human Servs., Office of the Assistant Sec'y for Planning and Evaluation (2011), *available at* https://www.cms.gov/mmrr/Downloads/MMRR2011_001_04_A01.pdf.
[4] Elayne J. Heisler et al., Cong. Research Serv., R44376, *Federal Support for Graduate Medical Education: An Overview* (2018) (reporting that when calculating the cost incurred by taxpayers for the entirety of the multiple GME programs including from the Centers for Medicare & Medicaid Services, Health Resources and Services Administration, Department of Veterans Affairs, and the Department of Defense, the total cost reached an estimated $16 billion), *available at* https://fas.org/sgp/crs/misc/R44376.pdf; U.S. Gov't Accountability Off., GAO-18-240, *Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding* (2018), *available at* https://www.gao.gov/assets/700/690581.pdf.
[5] *Mayo Found. for Med. Ed. & Research v. United States*, 562 U.S. 44 (2010).

environment under the supervision of more senior board certified physicians.[6] On average, these medical residents spend between 50 and 80 hours per week caring for patients.[7] The care they provide typically includes examining and diagnosing patients, prescribing medication, recommending plans of care, performing surgery, and other procedures.[8] Though the program is training-heavy and closely monitored at first, as medical residents progress they receive less supervision. Usually after the first year, medical residents have gained sufficient experience to work semi-independently, and also supervise and train more junior residents and medical students. Many Americans have received treatment from these medical residents and not recognized a difference in the quality of service provided. Medical residents are doctors that have already had many years of training, passed multiple state administered complex exams, and already received their Medical Degree.

Though medical residencies are important and have a long history in medical education, financial support by the American taxpayer is a more recent practice.[9] The idea stemmed from the belief that Medicare was not paying a fair share of the expenses incurred in educating doctors at a time when the government was becoming the largest payer of health care services.[10] It soon expanded to other government agencies that have health care responsibilities such as the Department of Veteran's Affairs (VA), Department of Defense (DOD), and the Health Resources and Services Administration (HRSA) who oversees the Children's Hospitals GME Payment Program (CHGME). The contribution and oversight of each agency's GME program differs but, on average, the Medicare GME program pays hospitals approximately $129,000 per medical resident slot with little transparency or accountability on how that money is spent.[11] The number of residency slots for which each hospital receives Medicare funding is allocated using a formula devised by statute.[12]

The Medicare GME payment was designed to cover Medicare's share of the costs incurred to train the medical residents, with the other costs borne by private insurance and the hospital.[13] Hospitals have long argued that aside from the direct cost of training a resident – such as resident salary, benefits, supervising physician salary, and overhead expenses – there are indirect holistic expenses associated with operating a residency program such as an overall slower pace of work, expenses from residents ordering more diagnostic tests than likely necessary, and from residents "learning by doing." Medicare attempts to account for this extra expense through *indirect* GME

---

[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Graduate Medical Education: Overview*, American Academy of Family Physicians (last visited Sep. 23, 2019), *available at* https://www.aafp.org/advocacy/informed/workforce/gme.html.
[10] H.R. Rep. No. 89-213, at 32 (1965) (House Committee on Ways and Means, *Social Security Amendments of 1965*).
[11] Marco A. Villagrana, Cong. Research Serv., F10960, *Medicare Graduate Medical Education Payments: An Overview* (2019) (stating that the federal government may be paying up to twice the amount that is empirically justified) (citing GAO 2017 report titled "Towards the Development of a National Strategic Plan for Graduate Medical Education"); *see also* U.S. Gov't Accountability Off., GAO-18-240, *Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding* 22 (2018), *available at* https://www.gao.gov/assets/700/690581.pdf.
[12] *See* U.S.C. §1395ww(h) (direct graduate medical education); *see also* 42 U.S.C. §1395ww(d)(5)(B) (indirect medical education).
[13] *See* Marco A. Villagrana, *Medicare Graduate Medical Education Payments: An Overview*, Medpac.gov (2019) *available at*, https://fas.org/sgp/crs/misc/IF10960.pdf.

payments, which accounted for approximately $7.38 billion in 2015.[14] By comparison, in the same year, Medicare paid out approximately $3.6 billion in *direct* GME payments, which accounts for resident salaries, etc.[15] According to MedPAC, which calculated the indirect costs of operating a residency program, Medicare is paying approximately twice as much as is empirically justified.[16] MedPAC's claim that Medicare may be paying a much larger share of the cost of training a resident than was intended is echoed by independent research conducted by the non-partisan Congressional Research Service.[17]

Additionally, Medicare does not adjust GME payments for any potential revenue generated or cost savings associated with the labor provided by the resident.[18] A hospital will pay approximately $61,200 on average per resident. But, as previously stated, the government pays the hospital approximately $129,000 per resident and hospitals receive several financial and non-financial benefits by operating a medical residency program, such as: subsidized labor (including on call coverage), the prestige of managing a residency program, increased donations, higher patient volumes, and the ability to negotiate higher prices from private payers, among other benefits.[19]

The Medicare GME program as currently implemented is subject to little oversight or transparency. In a 2014 report, the National Academy of Medicine (NAM) highlighted this concern stating that "[a]lthough the scale of government support for physician training far exceeds that for any other profession, there is a striking absence of transparency and accountability in the GME financing system for producing the types of physicians that the nation needs."[20] In the same report, the NAM went on to recommend increased "transparency and accountability of GME programs, with respect to the stewardship of public funding and the achievement of GME goals."[21] This lack of oversight and transparency has already led to government waste – a 2018 Inspector General report found that in seven out of eight audits performed, hospitals were counting residents **twice** for the purpose of receiving GME payments.[22] These payments are taxpayer dollars, and hospitals should be able to provide the public an account of how those funds are spent and be able to prove that the funds are geared toward the public good. To that end, hospitals also should

---

[14] *Id*.
[15] *Id*.
[16] MedPAC, *Medical education in the United States: Supporting long-term delivery system reforms: Chapter 1* 13, Medpac.gov (2009), *available at* http://www.medpac.gov/docs/default-source/reports/Jun09_Ch01.pdf?sfvrsn=0.
[17] *See* Marco A. Villagrana, *Medicare Graduate Medical Education Payments: An Overview*, Medpac.gov (2019) *available at*, https://fas.org/sgp/crs/misc/IF10960.pdf.
[18] *Id*.
[19] *See* The Do Staff, *What residents are getting paid in 2019*, thedo.osteopathic.org (July 23, 2018) *available at* https://thedo.osteopathic.org/2018/07/what-residents-are-getting-paid-in-2018/; Accreditation Council for Graduate Medical Education, *Common Program Requirements*, acgme.org (July 1, 2011), *available at* https://www.acgme.org/Portals/0/PDFs/Common_Program_Requirements_07012011%5b2%5d.pdf#page=16; MedPAC, *Medical education in the United States: Supporting long-term delivery system reforms: Chapter 1* 13, Medpac.gov (2009), http://www.medpac.gov/docs/default-source/reports/Jun09_Ch01.pdf?sfvrsn=0.
[20] Institute of Medicine of the National Academies Committee, *Graduate Medical Education that Meets the Nation's Needs*, Institute of Medicine of the National Academies (2014), *available at* https://www.nap.edu/resource/18754/GME-RB.pdf.
[21] *Id*.
[22] Office of Inspector Gen., Dep't of Health and Human Servs., A-02-17-01017, *CMS Did Not Always Ensure Hospitals Complied With Medicare Reimbursement Requirements For Graduate Medical Education* (2018), *available at* https://oig.hhs.gov/oas/reports/region2/21701017.pdf.

continuously monitor the needs of their communities and adjust their residency slots to ensure that they are training the doctors that are needed most.

The purpose of the GME program is to share the cost burden of training new physicians in medical specialty areas that will ultimately treat Medicare patients. The federal government has continued to fund GME in the same manner it did in 1965 when the Medicare program was created. That model was a hospital-centric one. Today, more and more health care is being delivered in the outpatient setting. For this reason alone, Congress should be evaluating the GME model to ensure that doctors are being trained in the environment in which they will practice medicine. With three separate reports by non-partisan institutes highlighting potential waste of these funds, Congress must take a closer look at the GME program to increase oversight and transparency, and ensure that taxpayer money is being spent in a manner that accords with congressional intent, and achieves the highest public good.[23] To that end, please respond to the following questions and provide a briefing to my office by October 31, 2019.

1. How many total medical residency slots is the government subsidizing through the GME program?

    a. How many are supported by Medicare?

    b. How many hospitals receive CHGME funding?

    c. How many are supported by DOD?

    d. How many are supported by the VA?

    e. How many remain unsubsidized and paid for by either the hospital or private insurance?

2. Since the 1980's, Congress has reduced the amount paid per residency slot several times. Since the most recent change in 2007, has the total number of medical residencies (subsidized and unsubsidized) increased or decreased? By how much?

3. How much did HHS spend on Medicare GME funding in total in fiscal year 2018?

4. What is the ratio of non-teaching hospitals (hospitals that do not operate a residency program) versus teaching hospitals (hospitals that operate a residency program) participating in the Medicare GME program? How has that ratio changed, if at all, since the program began?

[23] MedPAC, *Medical education in the United States: Supporting long-term delivery system reforms: Chapter 1* 13, Medpac.gov (Jun. 2009), *available at* http://www.medpac.gov/docs/default-source/reports/Jun09_Ch01.pdf?sfvrsn=0.

5. With what frequency has HHS consulted in working groups with other federal agencies (Veterans Affairs, Department of Defense, etc.) to jointly develop best practices, ensure consistency, and that there is not duplication of payments?

    a. How does HHS specifically ensure that these best practices are maintained in the GME programs that it oversees?

    b. How does HHS specifically ensure consistency through the GME programs that it oversees?

    c. How does HHS specifically ensure that there is not duplication of payments to hospitals by the programs that it oversees as well as GME programs that overseen by other government agencies?

6. How does HHS verify that the number of medical residents participating in the program corresponds to the residency spots it funds?

7. To your knowledge, has any private or government entity reviewed the GME program at the hospital level to determine the cost of training per resident versus the benefit incurred by employing residents?

8. How do the costs and benefits of employing residents change over the duration of the residency? How does the length of residency affect that analysis? How does the specialty of the resident affect these costs and benefits?

9. Hospitals incorporate indirect costs associated with residents but not indirect benefits. Has HHS calculated the indirect benefits hospitals receive by operating a medical residency program?

    a. Have hospitals provided evidence and statistics showing the benefit that a teaching hospital receives per resident including labor savings?

10. Does the current system allow the government to target GME program assistance to specific geographic regions or specialties where there is a clear physician shortage?

11. What tools are available to CMS to ensure that states with the greatest needs per capita and the greatest needs per specialty are receiving assistance under the GME program?

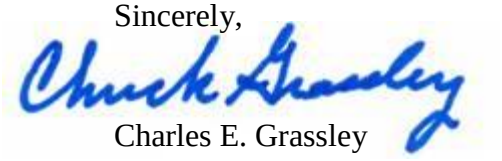
12. Rural states such as Iowa are among the states with the greatest need for doctors.[24] Please provide detailed statistics concerning the number of Medicare GME supported residents per capita, and by specialty, in rural states compared to other states.

---

[24] *See generally* Joshua Ewing and Kara Nett Hinkley, *Meeting the Primary Care Needs of Rural America Examining the Role of Non-Physician Providers*, National Conference of State Legislatures (2013), *available at* http://www.ncsl.org/documents/health/RuralBrief313.pdf.

Should you have questions, please contact Dario Camacho or Daniel Boatright of my Committee staff at (202) 224-4515. Thank you for your attention to this important matter.

Sincerely,



Charles E. Grassley
Chairman
Senate Committee on Finance

cc:
Thomas J. Engels
Acting Administrator
Health Resources and Services Administration

The Honorable Seema Verma
Administrator
Center for Medicare & Medicaid Services

Joanne Chiedi
Acting Inspector General
Department of Health and Human Services

The Honorable Michael J. Missal
Inspector General
Department of Veterans Affairs

Glenn A. Fine
Principle Deputy Inspector General
Department of Defense