HEALTH POLICY REPORT

Medicare, Graduate Medical Education, and New Policy Directions

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It has been more than a decade since Congress enacted legislation that significantly altered the policies under which Medicare supports graduate medical education (GME). Now, the political ground under this relationship is beginning to gradually shift again, and if this development gathers momentum, it could lead to greater support for the training of primary care physicians and more scrutiny overall of how these Medicare GME monies are spent. As an increasing number of medical-school graduates pursue specialties with a "controllable lifestyle" and shun careers in primary care, there are distinct signs that Congress will face new demands to examine Medicare payments to teaching hospitals. Although the forces fueling greater specialization are far more powerful than any potential incremental change in federal policy, the Medicare Payment Advisory Commission (MedPAC) has pledged to examine physician workforce issues more closely, "especially with respect to the supply of primary care providers" and "the choices medical students and residents make about their career specialty."[1] As a first step that reflected its concern, in its latest report the commission recommended that Congress increase Medicare fees to primary care physicians in a budget-neutral fashion. This proposal provoked controversy because budget neutrality means, one way or another, that fee adjustments that are intended to award physicians who deliver primary care services would divert money from practitioners who do not — most of whom are specialists.[2]

In this report, I discuss key issues that surround GME policy as it relates to Medicare and Medicaid. These matters are integral to the consideration of a broader issue: whether a shortage of physicians exists or soon will exist, as the academic medical community and an array of other interested parties assert, and if so, whether the government should take action to increase the supply of doctors or influence the mix of generalists and specialists.[3] Although there is no consensus on the issue of physician supply, the adequacy of the workforce may become a more pressing matter if the next administration seeks to extend coverage to millions of uninsured people and discovers that there is an insufficient number of doctors, nurses, and allied personnel available to care for them. Newly insured people in Massachusetts and a few other states have already reported that they are having problems making appointments with physicians in some locales.[4,5] The Institute of Medicine recently reported the findings of a study that documented an acute shortage of geriatricians as the baby-boom population nears retirement.[6]

A LONG-STANDING FEDERAL COMMITMENT TO SUPPORT GME

In 1965, when Congress enacted the legislation that created Medicare, it assigned to the program functions that reach well beyond its basic mission of providing health insurance to an eligible population that now numbers 45 million people who are elderly, disabled, or have end-stage renal disease. One of the most important of these functions provides substantial support to the training of new physicians through GME programs, most of which are operated by major teaching hospitals.[7] At the time of enactment, Congress determined that educational activities in teaching hospitals should be regarded as a reimbursable expense by Medicare until "the community [society at large] undertakes to bear such education costs in some other way."[8,9] Fast-forward 43 years and, despite attempts to broaden the explicit sources of support (from private insurers, for example) for training new physicians through GME, no policy has ever been crafted to achieve this goal of academic medicine. In 2007, Medicare provided $8.8 billion to teaching hospitals in support of their GME programs and re-

lated patient-care activities. Private insurers do support GME implicitly through the higher payments they negotiate with teaching hospitals on behalf of the inpatients they cover. Although one report estimated that private insurers contributed $7.2 billion in support of GME in 2006,[10] it is almost impossible to calculate such a number because the portion of these higher prices that defrays the costs of advanced training is neither separately negotiated nor specifically identified. Regardless, private insurers have strongly opposed any public policy that would mandate that they pay a portion of GME expenses.

THREATS TO FEDERAL SUPPORT OF GME

Of the federal programs and agencies that support GME (e.g., Medicare, Medicaid, and the Departments of Defense and Veterans Affairs), Medicare has become the major battleground for debate over GME policy, because among these sources its contribution is by far the largest. Medicare recognizes the costs that teaching hospitals incur in training and other activities in two ways. First, it provides direct payments for medical education to hospitals that cover a share of the stipends paid to residents, salaries of supervising faculty, and other allowable program expenses. Second, it provides an indirect medical-education adjustment, the goal of which is to cover the added patient-care costs associated with training.

On February 4, the Bush administration submitted its 2009 budget to Congress and proposed reductions in an array of domestic programs, including Medicare and Medicaid, while calling for increases in spending on defense and homeland security. The budget also would extend tax cuts that expire in 2010 and which Democrats have criticized as mostly benefiting wealthy people. If enacted, the budget would slow the annual growth rate of Medicare over 5 years (from 2009 through 2013) from 7.2% to 5.0% by reducing expenditures by $182.7 billion over this period. Medicare expenditures totaled $432 billion in 2007.

Among the cuts sought by the administration is one that would decrease by 60% over 3 years the add-on payments that Medicare makes to teaching hospitals for their expenses for indirect medical education; these payments are based on the number of residents these hospitals employ. In 2008, for every 10 residents per 100 beds, a teaching hospital received a 5.5% add-on adjustment to its Medicare payment rate for hospital care. Indirect payments for medical education to training facilities totaled about $5.8 billion, three quarters of which went to major teaching hospitals and averaged about $14 million per institution. The lowering of the add-on payments for indirect medical education from 5.5% to 2.2% would yield savings to Medicare of $12.9 billion over 5 years. The administration's proposal is consistent with an analysis by MedPAC that concluded that "the current adjustment is set at more than twice what can be justified empirically, directing more than $3 billion in extra payments to teaching hospitals with no accountability for how the funds are used."[2] The president's budget also proposed to eliminate the adjustment for indirect medical education that teaching hospitals receive when they treat patients who are enrolled in Medicare Advantage, the program's managed-care component. The elimination of this adjustment would yield estimated savings to Medicare of $8.85 billion over 5 years.

In yet another attempt to reduce federal support for GME, the administration also proposed a regulation in 2007 that would bar state Medicaid programs from using any of their federal matching dollars to fund advanced medical training in hospitals within their states. Overall, the federal government pays about 57% of the costs of Medicaid, an estimated $204 billion in fiscal 2008. In 2005 (the latest estimate available), Medicaid provided support totaling $3.2 billion to GME programs within their respective states.[11] The release of the administration's 2009 budget provoked concern in the academic medical community; however, in all likelihood, Congress will accept very few of these proposed spending reductions.

THE FITS AND STARTS OF U.S. PHYSICIAN WORKFORCE POLICY

After supporting GME through Medicare's open-ended payment policies for more than 30 years, Congress, in the Balanced Budget Act of 1997, placed a cap on the number of residency positions that the program would support.[12,13] The law stipulated that Medicare would not pay its share of the allowable GME costs of residents in allopathic and osteopathic medicine beyond the costs of the number of residents who were training in a given teaching hospital as of December 31, 1996. At the time, there was no opposition to

the cap.[14] Indeed — reflecting the fits and starts of U.S. physician workforce policy — the provision was actually supported by six major medical organizations. These organizations issued a consensus statement in 1996 that asserted that the United States was on the verge of a serious oversupply of physicians. As a consequence, they said, the number of entry-level GME positions should be aligned more closely with the number of graduates of U.S. medical schools, and "this realignment should be achieved primarily by limiting federal funding of GME positions."[15]

In 2006, the Association of American Medical Colleges (AAMC), one of the six organizations, reversed its position and recommended the enrollment of 30% more students in schools of allopathic medicine than the 16,488 enrollees in 2002, or an additional 4946 students, by 2015.[16] In addition, it called for elimination of the cap on Medicare-supported GME positions and an increase in entry-level residency positions. The association said its policy reversal derived from the failure of tightly organized managed-care plans to materialize as the major delivery model in the United States. Had this development occurred, the AAMC said, it would have "drastically change[d] the way that health care is organized and delivered." The American Medical Association is also on record as favoring an increase in the capacity of U.S. medical schools to educate doctors.

EFFORTS TO LIFT THE MEDICARE GME CAP

Legislation has been introduced in the House and the Senate to modify the cap policy, but the scope of this policy is limited and the formula for creating new residency positions is complex. The measure would support new training positions only in the 24 states in which the ratio of resident physicians to the population is below the national median. The AAMC estimates that 1222 new positions, slightly more than 1% of the total number of positions that Medicare currently supports in the entire country, would be eligible for Medicare support under the legislation (Knapp RM: personal communication). To limit the costs associated with this policy shift, the new positions would be phased in over a period of 5 years. In addition, the Department of Health and Human Services would be required to determine whether a hospital seeking to add positions could fill them within 3 years. It would also be required to take into consideration (but not dictate) whether the new slots would be in primary care, preventive medicine, or geriatrics. Although the legislation has influential sponsors, including Senate Majority Leader Harry Reid (D-NV) and Senator Bill Nelson (D-FL), its early enactment is unlikely, given the overall financial challenges that Medicare faces and the substantial support the program already provides to teaching hospitals. Moreover, because of the limited scope of the legislation, many major teaching hospitals would derive little or no benefit; thus, support for the measure has been less than strong.

Underscoring the value that teaching hospitals attach to their educational mission and to residents who provide considerable amounts of patient care during their on-the-job training at low salaries, these facilities have created approximately 6500 new positions that receive no GME support from Medicare. In 2002, the number of residents in GME programs approved by the Accreditation Council for Graduate Medical Education (ACGME) totaled 98,258. By 2006, that number had risen to 104,879, an increase of 6.3%. But relatively few of these new positions are entry-level slots, the expansion of which the AAMC is advocating. According to Michael Whitcomb, a former senior vice president of the AAMC,

> Virtually all of the positions that were added [by teaching hospitals after imposition of the Medicare cap] increased the number of subspecialty fellowship positions in the system. Thus, if the removal of the caps simply allows teaching hospitals to continue recent practices, it will have no meaningful effect on the number of PGY-1 [first postgraduate year] positions. Accordingly, it will have no impact on the aggregate supply of physicians in the long term. Thus, any policy that evolves at the federal level to increase physician supply must link the removal of the caps to an increase in PGY-1 positions.[17]

However, increasing the number of PGY-1 positions may not necessarily increase the number of trainees who enroll in primary care programs. The reason is that the number of slots in family medicine (the specialty that produces the largest number of doctors who devote their practices to primary care) that are filled by all appli-

cants, including graduates of foreign medical schools and colleges of osteopathy, has been decreasing for a decade and has decreased precipitously among graduates of U.S. medical schools (Table 1). In 1997, of 3262 training positions offered in family medicine, 2905 (89.1%) were filled — 71.7% by graduates of U.S. medical schools. In 2008, of the 2654 positions offered in family medicine, 2404 (90.6%) were filled but only 1172 (44.2%) were filled by graduates of U.S. schools. The total number of matches in family medicine in 2008 represented a modest increase from 2313 matches in 2007. Overall, the latest results, which were released March 30 by the National Resident Matching Program, again underscored the increasing popularity of specialties that have a more controllable lifestyle.[18-21] These specialties enable physicians to schedule more regular hours and, in most cases, earn incomes well above those of primary care doctors. Specialties that generally fall into this category include anesthesiology, dermatology, emergency medicine, neurology, ophthalmology, otolaryngology, pathology, plastic surgery, psychiatry, and radiology.

In its 2006 statement on the physician workforce, the AAMC emphasized that "individual medical students and physicians should be free to determine for themselves which area of medicine they wish to pursue and GME programs and teaching hospitals should be free to offer training in specialties they wish to offer if accredited by the ACGME."[16] By contrast, a 2008 report issued by the Association of Academic Health Centers, which has 100 member institutions that consist of a medical school and one or more other schools that provide training in a health profession, called for sweeping change that would recognize broader societal considerations. The report asserted that "traditional approaches to decision making are no longer viable" and recommended the creation of "an integrated, comprehensive national health workforce policy that recognizes and compensates for the inherent weaknesses and vulnerabilities of current decentralized and distributed multistakeholder decision making."[22]

CHANGES IN THE WIND OVER HEALTH WORKFORCE POLICY

Fifteen years ago, the Clinton administration, individual members of Congress, and the Physician Payment Review Commission all put forward proposals that called for federal regulation of the mix of generalist and specialist residents who were supported by Medicare. These schemes never generated much support and lost favor as Repub-

Table 1. Number of Applicants Matched to Family-Medicine Programs According to Applicant Type, 1997 and 2008.

Applicant	1997			2008		
	Applicants (N=2905)	Placements (N=2905)	Positions Offered (N=3262)	Applicants (N=2387)	Placements (N=2387)	Positions Offered (N=2636)
	no.	%	%	*no.*	%	%
Senior in allopathic medical program	2340	80.6	71.7	1156	48.4	43.9
Non-U.S. citizen, student or graduate of international medical school	198	6.8	6.1	494	20.7	18.7
Student or graduate of osteopathic medical program	159	5.5	4.9	264	11.1	10.0
U.S. citizen, student or graduate of international medical school	103	3.5	3.2	397	16.6	15.1
Student or graduate of fifth-pathway program*	66	2.3	2.0	6	0.3	0.2
Previous graduate of allopathic medical program	35	1.2	1.1	69	2.9	2.6
Canadian citizen	4	0.1	0.1	1	<0.1	<0.1

* The fifth pathway is an avenue by which students who have attended a foreign medical school for 4 years may complete their supervised clinical work at a medical school in the United States and become eligible for residency training in the United States. Such students who successfully complete residency training can ultimately obtain a license to practice in the United States. Data are from the National Resident Matching Program.

licans gained control of the government during and after the end of the Clinton administration. The Bush administration has been particularly opposed to regulating the composition of the physician workforce. It believes that the market will equilibrate any distortions in the number and types of doctors, and it proposes, time and again, to zero out virtually all of the programs in the health professions that have been authorized under Title VII of the Public Health Service Act. The administration has also thwarted or delayed the release of health workforce studies that have suggested government action; most of these studies have been prepared by the Council on Graduate Medical Education (COGME) and produced under contract with other offices of the Health Resources and Services Administration. When agencies that advise Congress (e.g., the Congressional Budget Office, the Government Accountability Office, and MedPAC) have recommended major alterations in workforce policy or issued reports that propose to do so,[23-25] legislators have opted for approving only incremental changes and have left many issues untended.

In recent months, however, somewhat stronger interest has begun to emerge on physician workforce issues because of the decreasing number of students who are pursuing careers in primary care. Several interested groups have also expressed concerns that an overall shortage of doctors looms or already exists in some locales and, thus, medical schools should expand their capacities to educate students.[3] Thus far, these developments have provoked only a few ripples in Congress, and they do not begin to match the dire forecasts of groups such as the American College of Physicians, which asserted that "primary care, the backbone of the nation's health care system, is at grave risk of collapse."[26-31]

The most active, government-based policy discussions on physician workforce issues have emerged from the COGME and MedPAC, which is the more influential of the two advisory groups. In its June 2008 report, MedPAC expressed the view that "beneficiary access to high-quality primary care is essential for a well-functioning health care delivery system," but it noted that because these services are undervalued, they are at risk of "being underprovided to the Medicare population."[2] The commissioners signaled their interest in tying future federal support of GME to training in particular specialties when they suggested in their latest report that

> policymakers could consider ways to use some of these [Medicare] GME and [indirect medical education] subsidies toward promoting training in primary care. For example, a portion could be targeted specifically to support medical residency positions in primary care. Similarly, allocating shares toward nurse practitioners and physician assistants — integral partners in managing patients' chronic conditions — could be useful for promoting primary care services.

The commissioners were critical of the growing emphasis on specialty care, asserting that "areas with more specialist-oriented patterns are associated with higher spending, but not improved access to care, higher quality, better outcomes, or greater patient satisfaction." To reach its conclusions, the commission relied heavily on the findings of researchers at Dartmouth Medical School,[32-34] who have conducted studies that have also influenced the Congressional Budget Office.[35]

MEDPAC RECOMMENDATIONS PROMOTING PRIMARY CARE

On the basis of these views, MedPAC made two recommendations to Congress in its new report. First, legislators should make an upward adjustment of Medicare fees for primary care services such as office and home visits, which are billed under the physician fee schedule. The adjustment would also increase payments for services when they are furnished by physicians, advanced practice nurses, and physician assistants who have focused their practices on primary care. Second, Congress should initiate a pilot project designed to determine the value that a "medical home" could provide to Medicare beneficiaries. It should also provide the program with an opportunity to structure payment incentives for primary care activities such as care coordination, which are sorely needed by many patients[36] and called for by professional associations.[37]

For purposes of this article, the most important of these recommendations would adjust upward Medicare fees for primary care services because the effect of this adjustment would be more immediate. If enacted, the adjustment would be instituted on a budget-neutral basis; thus, it would come at the expense of specialists' fees. Providers could receive the adjustment if primary care ser-

vices, as a percentage of their practices, met a certain threshold. The commission considered thresholds in a range of 40 to 75% of a primary care practice and payment adjustments of 5% and 10%. For example, allowed charges for an eligible physician would increase by at least 5.6% with an adjustment of 10% and a threshold of 60%. Physicians in geriatric medicine and family practice would most likely be the major beneficiaries of the fee adjustment because, on average, they devote the largest percentage of their practice time to primary care. Although these payment adjustments would be an improvement in the fees paid to physicians who deliver primary care services, their incomes would still be well below those of doctors who perform procedures (Fig. 1).

CALLS FOR GME REFORM AND GREATER ACCOUNTABILITY

With virtually no staff to call on, members of the COGME have had to write their own reports.[39,40] However, because most of its members are practitioners of one kind or another — specialists, family physicians, and leaders of academic medical centers and nonprofit health systems — rather than strictly policy analysts, they bring some credibility to the reports that derives from their operational experiences. Dr. Russell G. Robertson, chairman of the Department of Family Medicine at Northwestern University, presides over the council. In one of its recent reports, the council recommended an increase of 15% in the number of Medicare-supported GME positions.[40] (MedPAC has not adopted a position on that issue.) At the same time, COGME urged Congress to broaden the definition of an eligible "training venue" beyond that of the inpatient setting, pointing out that

> GME funds are tied to inpatient, hospital-based care, while medical practice and education are shifting more to the ambulatory setting for both primary care and specialty care services. . . . The future practice of medicine, and therefore training, should be coordinated, interdisciplinary, and patient-centered, rather than fragmented among multiple unrelated providers and settings of care. Unfortunately, the current GME funding streams continue to perpetuate an outmoded style of medicine.

The COGME and MedPAC have also recommended that teaching hospitals be held to greater accountability for the public monies they spend on training new physicians. Underscoring this

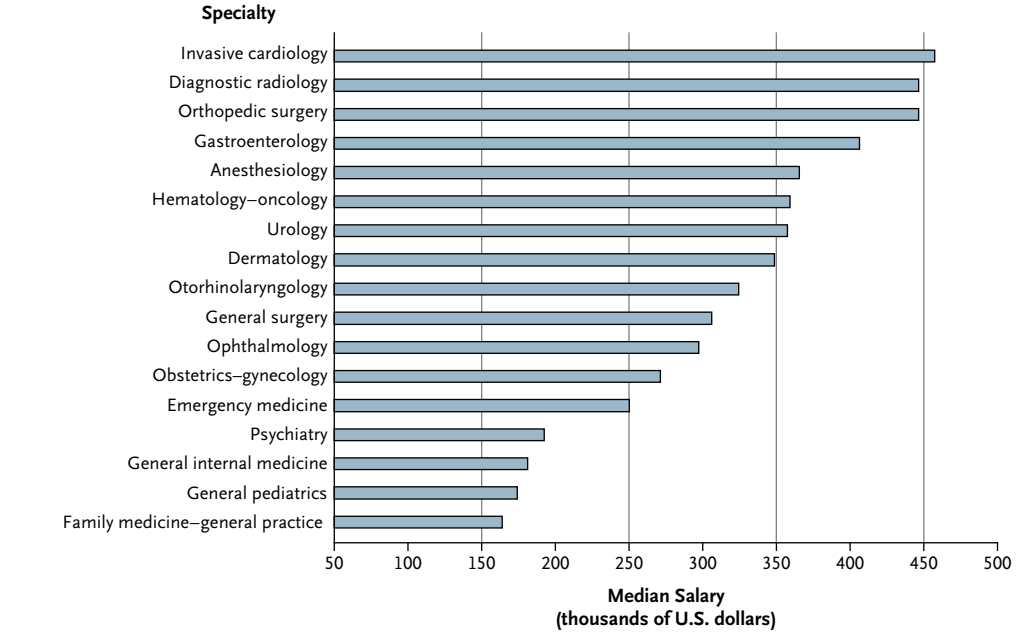

Figure 1. Median Salary According to Medical Specialty, 2006.
Data are from the Medical Group Management Association.[38]

view, the chairman of MedPAC for 8 years, Glenn Hackbarth, said at its public meeting in January 2007 that he had the "utmost respect" for teaching hospitals, but he added, "my perennial concern . . . has been that the current [indirect medical education] system is problematic . . . because there is no accountability for what's produced . . . I would like to see . . . appropriate funding for these important institutions coupled with more accountability."[41]

NEW ADVOCATES FOR PRIMARY CARE

Given the overriding emphasis on specialization and the beleaguered state of primary care, a variety of concerned persons and organizations have launched efforts to resurrect the role of the generalist physician in the medical workforce. A coalition of large employers, consumer groups, professional associations, and other stakeholders, spearheaded by IBM and organized as the "patient-centered primary care collaborative," has coalesced around the model of the medical home as its preferred way of promoting primary care.[42,43] In describing its intent, the collaborative said,

> Employers that subsidize health care coverage want to provide access to care that delivers excellent outcomes, creates patient confidence and satisfaction and is affordable for all who pay — a challenge we have yet to meet. . . . Research studies in countries where patient–physician relations focus on primary care consistently show that people live longer, populations are healthier, patients are more satisfied with their care and everyone pays less.[44]

The coalition has persuaded the presumptive Republican and Democratic presidential nominees to endorse the concept of a medical home (Grundy P: personal communication).

The AARP has begun to express its concerns over the decline of primary care on behalf of its membership of 39 million people who are 50 years of age or older. John Rother, group executive officer of policy and strategy for AARP, said in an interview that I conducted, "Primary care is key to more effective and efficient delivery of services, especially for individuals with multiple chronic conditions. We support changes in physician reimbursement that will generate a more appropriate mix of physicians going forward." In another recent interview, Mark B. McClellan, administrator of the Centers for Medicare and Medicaid Services from 2004 to 2006, said,

> There are increasing calls for GME reform but that has not translated into broad support for changes that could save some money and provide better support for training physicians in innovative approaches to coordinate care, enhance care for disadvantaged populations and develop better models of translational research. These are vital goals that need further development as soon as possible.

CONCLUSIONS

The new expressions of concern over the composition and size of the physician workforce, mixed with the prospect of a new era of discussions about health care reform, could renew the debate about medical specialties and about how many doctors are enough. Should this debate develop, policies designed to encourage more medical-school graduates to pursue careers in primary care will, in all likelihood, focus on financial incentives rather than (as it did 15 years ago) on the creation of a national commission that would allocate residency positions among specialties.[45] However, this impulse is a long way from fruition given the large differential in fees that separates generalists and specialists, the American preference for private decision making, and the reluctance of government to wade into this complex arena that could deteriorate into a pitched battle between physicians with conflicting economic interests.

Advocates of primary care practitioners believe that nothing short of a major overhaul of economic incentives would attract more medical-school graduates to pursue careers as generalist physicians. But to achieve this goal will take nothing less than a vigorous public uprising that compels policymakers and private stakeholders alike to acknowledge the value of making primary care a centerpiece of a restructured health care system, as is the case in most other industrialized nations, and acting accordingly. That kind of commitment on behalf of primary care may emerge in the future, but it is not on the American horizon today.

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