Graduate Medical Education: Proposals to Modify Medicare Financing

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Overview:

• AAMC’s Key Points on GME Policy
• Responses to Critics
• Common Ground to Build On
First, who we are…
AAMC: Med. Schools, Hospitals, MDs

• Membership includes:
  ✓ 145 U.S. medical schools (MD programs)
  ✓ Nearly 400 major teaching hospitals and health systems
    ▪ 51 Department of Veterans Affairs medical centers
  ✓ Over 90 Academic and scientific societies

• Over 300,000 “Voices:”
  ✓ 141,000 faculty members
    ▪ Clinical and basic science (research) faculty
    ▪ Staff the physician practice groups and hospitals
  ✓ 83,000 medical students
  ✓ 115,000 residents
Academic Medicine: Disproportionate Provider of Patient Care, Research, Training

- **5%** of all U.S. hospitals are COTH hospitals
- **23%** of all hospital care
- **20%** of all Medicare In-patient days
- **24%** of all Medicaid in-patient days
- **37%** of charity care

Teaching hospitals provide critical services often not available elsewhere.

- **50+%** of NIH Extramural Research Awards
- **74%** of all residents

Source: Table G5, Inpatient and Outpatient Operations Data Fiscal Year 2012 Data, AAMC Data Book, April 2014
AAMC’s Five Key Points
In Sum, AAMC’s Key Points:

1. The nation faces a major physician shortage that could jeopardize access to care for all – largely due to aging population.

2. We need a multi-faceted response: delivery & financing reforms, programs addressing maldistribution, new GME accountability, and more GME slots.

3. Congress created Medicare GME policy to ensure seniors have access to care they need. Delinking GME payments from Medicare would jeopardize Medicare’s purpose and effectiveness.

4. Despite IME’s name, Congress intended IME payments to support teaching hospitals’ sicker patients & services such as trauma, burn, inpt psych, which most others don’t provide.

5. Given Medicare’s complexity and impact on all health care, effective GME reform needs to be implemented incrementally.
1. The nation faces a major physician shortage that could jeopardize access to care for all – largely due to aging population.

- AAMC commissioned I.H.S. Inc. to produce physician workforce projections under multiple scenarios.

- They included demographic change, physician practice, ACOs, NP growth, retail clinics.

- In every scenario, projections pointed to national shortages – among physicians overall and specialists.

- The projections are not perfect. That’s why they are reported in broad ranges.

- That’s also why we plan to update them annually.
IHS Supply Versus Demand Projections: Shortage of Physicians in Every Scenario
In Sum: IHS’ *National* Physician Workforce Projections for 2025

**Primary Care:** 12,500 – 31,100 shortage

**Specialty Care:** 28,200 – 63,700* shortage
- Med specialists – 5,100 – 12,300
- Surg specialists – 23,100 – 31,600
- Other specialists – 2,400 – 20,200

**All Physicians:** 46,100 – 90,400* shortage

Surgical Specialists = Up to ½ of shortage

* Projections don’t add up because of microsimulation model used
Growth in Elderly Population Is Fastest
A Growing, Aging Population Matters

Physician utilization/100,000 people by age

Senior Citizens’ Utilization More than Double that of Younger Generations
Future Is Here: In July 2015, 67% of VA Physician Vacancies = Specialists

**Percent of VA Physician Vacancies**

- 67% = Specialists
- 30% = PC
- 3% other

Other = Non-Care Givers

Source: AAMC Analysis of Job Postings from VA Physician Careers Website, as of July 2015

2. We need a multi-faceted response: delivery and financing reforms, programs addressing maldistribution, new GME accountability, and more GME slots.

Advance health care, finance delivery reforms.
- Medical schools, teaching hospitals = leaders in all.

Fund programs to address physician maldistribution, targeted workforce needs.
- Help rural, comm. hospitals develop training programs.
- Pass HR 1117 – CMS grants to states.
- Enact funding for NHSC, Title VII, THCs, CHGME.

Advance GME accountability standards.
- Pass accountability legislation along lines of Training Tomorrow’s Doctors Today Act. AND

Enact modest increase in Medicare GME support.
- Pass HR 2124, S 1148 – Medicare GME support for 3,000 more residents per year for each of 5 years.
3. Congress created Medicare GME policy to ensure Medicare gives seniors access to the care they need. Delinking GME payments from Medicare would jeopardize Medicare’s effectiveness.

Medicare GME policy is Medicare policy.
- It’s not federal GME policy.

Medicare GME payments are intended to pay only Medicare’s share of the extra costs of teaching hospitals.
- They do not pay all GME costs.

In the last 30 years, Medicare GME payments have become the only major and reliable source of GME.
- Only because other payers ceased to be willing to pay extra.
- It was never Congress’ intention.

Medicare GME support is critical. But teaching hospitals still shoulder most of the cost of GME.
Medicare Only Covered 20% of All DGME Costs of Teaching Hospitals in FY 2012

Teaching Hospital DGME Costs FY 2012

Total DGME Costs = $12.9 billion + $3.3 billion = $16.2 billion

- Medicare Payments: $3.3 billion
- DGME Costs Absorbed by Hospitals: $12.9 billion
Congress created IME because of concerns about the inability of Medicare coding to “account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents…”


“…to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals.”

U.S. Congress, 1999
1 Hospital’s Estimate of What It Would Take to Absorb Loss of IME Payments

- **< Staff:** Reduce staffing 8% = 385 FTEs or $25 million
- **< Residents:** Reduce residency programs by 75-100 residents
- **< Services:** Further reduce or close mental health services, other services with poor margins - e.g., burn units
- **< Access:** Decrease access to select ambulatory services, e.g., sickle cell, geriatric, coagulation, CHF clinics
- **< Transfers:** Decrease access to transfers from surrounding community hospitals seeking specialized service
- **< Research:** Reduce research support
5. Given Medicare’s complexity and impact on all health care, effective GME reform needs to be implemented incrementally.

Medicare is so complex and extensive, it affects all of health care, not just senior citizens’ care.

Medicare GME policy is a good example.
- It affects all of academic medicine.
- It affects patient care, training, and research.

Medicare is not perfect; neither is Medicare GME policy.
- But sweeping reform can have serious unintended consequences; recognized by the IOM committee.

Medicare reform should begin incrementally.
- The best place to start is development of GME accountability.
- We all agree on the need for GME accountability.
Response to Critics
Critics say: “There won’t be a physician shortage, because bundled payments, ACOs, new health professionals, retail care are changing health care.”

These reforms have potential but evidence is not in yet.

Preliminary evaluations of delivery, financing changes are only just coming in.
  - e.g.: Years before peer-reviewed evidence will be in.

For now, preliminary evidence is mixed – signs of potential, but not consistent
  - e.g.: Official evaluations of two years of Pioneer ACOs show some ACOs succeed, others do not.

  • History teaches us: Beware of what we assume.
    - e.g.: 1990s assumptions about managed care.
Critics say: “Projections have never been correct. They’re not even directionally correct. It’s a mistake to make plans based on them.”

They’re based on assumptions because of lack of data.
- e.g.: 1990s assumption that close panel managed care would dominate health care. It didn’t.

They influence physician decision-making about practice, location, which results in change.
- e.g.: 1990s surplus projections led to drop in physicians entering anesthesiology.
Critics say: “Medicare GME policy is not producing the workforce we need: access to primary care, care in rural and underserved areas; a diverse workforce; high quality, low cost care.”

The purpose of Medicare policy is to ensure Medicare patients have access to the care they need.

Using Medicare GME policy to effect maldistribution has not been successful.

- Medicare GME pays more for primary care training but has not changed primary care supply.
- Medicare GME favors rural training in several ways but has not changed rural physician supply.
“Health care reimbursement and the organization of health care services, for example, are far more important than GME in determining the makeup and productivity of the physician supply...”

The IOM Committee on the Governance and Financing of Graduate Medical Education, “Graduate Medical Education that Meets the Needs of the Nation,” 2014
Critics say: “AAMC’s new projections are not credible. They don’t factor in new payment delivery models, such as tele-health or PAs.”

AAMC is 1st to recognize IHS projections are not perfect.

They are based on the best data available, but data are often far from what is needed.

- We are committed to developing ever more refined projections on an annual basis.

AAMC will release updated projections next year.

- 1 area of potential improvement is focusing on PA data.
- We also are exploring data to better understand NP and PA roles in delivering current care versus additional care.
- Also tele-health development, data.

Projections = analytical tools, not guarantors of future.

- Must be used carefully, aware of limitations.
Total Active Physicians by Largest Specialties, 2014

Source: AMA Physician Masterfile (December 31, 2014)
ACGME Residents by Specialty in 1st Year of Program, 2014-2015

- **Primary Care**: 7,479 residents
- **ER Med**: 2,842 residents
- **Psych**: 1,877 residents
- **Anesthes.**: 1,326 residents
- **OB/GYN**: 1,258 residents
- **Rad**: 1,172 residents
- **Gen Surg.**: 1,210 residents
- **Card (IM)**: 881 residents
- **Ortho Surg.**: 729 residents
- **Path**: 617 residents
- **Neruo**: 679 residents
- **Hem/Onc (IM)**: 560 residents
- **Ophtho**: 477 residents
- **GI (IM)**: 512 residents
- **Pulm/CC (IM)**: 536 residents
- **Nephro (IM)**: 436 residents
- **C&A Osych.**: 415 residents
- **Derm**: 438 residents
- **Infec (IM)**: 366 residents
- **IM/Peds**: 372 residents
- **PMAR**: 352 residents
- **ENT**: 304 residents
- **Inter Card (IM)**: 309 residents
- **Pain (Anesth)**: 332 residents
- **Urolog.**: 302 residents
- **Endo/DM (IM)**: 300 residents
- **Geriatrics**: 249 residents

**Total Year-1 Residents**
- **IM**: 7,479 residents
- **FM**: 3,578 residents
- **Peds**: 2,294 residents

- **IM**: 38% not likely to subspecialize
- **FM**: 85% likely to subspecialize
- **Peds**: 53% likely to subspecialize

The Critics say: “We need to move GME training from Northeast to states with regional, local physician shortages.”

Little evidence to suggest that would have big impact.
- IOM committee recognizes payment policy, other factors have more impact than GME policy on maldistribution.

Medicare GME policy favors rural hospitals in a number of ways, but rural physician shortages persist.
- Rural teaching hospitals have a 30% higher GME cap.
- “Critical Access” hospitals have no GME cap.

No guarantee: Some states with low doc/pop ratios still export more than half the residents they train.
- e.g.: IA exports 60% of its residents to 49 states.

Even if rural states receive less Medicare GME $, they receive docs trained in other states with Medicare $.
- e.g.: MT imports 97% of its docs trained in other states.
Will Moving GME Programs to States with Low Doc/Pop Ratios Help?

Examples of States with Low Doc/Pop Ratio and Lower GME Retention Rates

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<thead>
<tr>
<th>Doc/100k Pop</th>
<th>GME Retention Rate</th>
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<tbody>
<tr>
<td>• IA</td>
<td>211</td>
</tr>
<tr>
<td>• KS</td>
<td>214</td>
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<tr>
<td>• WY</td>
<td>197</td>
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<tr>
<td>• Nat’l. Ave.</td>
<td>266</td>
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<tr>
<td>• State Median</td>
<td>251</td>
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Will Moving GME Programs to States with Low Doc/Pop Ratios Help?

Examples of States with High Doc/Pop Ratio and Lower GME Retention Rates

<table>
<thead>
<tr>
<th>State</th>
<th>Doc/100k Pop</th>
<th>GME Retention Rate</th>
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<tbody>
<tr>
<td>NH</td>
<td>300</td>
<td>26%</td>
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<tr>
<td>RI</td>
<td>347</td>
<td>30%</td>
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<tr>
<td>VT</td>
<td>338</td>
<td>31%</td>
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<tr>
<td>Nat’l. Ave.</td>
<td>266</td>
<td>47%</td>
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<tr>
<td>State Median</td>
<td>251</td>
<td>45%</td>
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But VT Still Trained Docs for 41 Other States

2014 practice locations of physicians who completed GME in VT from 2001 to 2006

- 1-5 physicians
- 6-10 physicians
- 11-50 physicians
- 51-100 physicians
Opportunities for Non-Teaching Hospitals to Receive Medicare Support for New Programs

• Rural hospitals can take advantage of GME cap preferences.  But they don’t.

• Critical access hospitals can take advantage of no GME caps.  But they don’t.

• Most hospitals nationwide can be teaching hospitals.  But they’re not.

• Teaching hospitals dominate delivery of money losing services – e.g., psych, burn units.
Where Should We Focus?

Our Differences or Our Common Ground?

MedPAC, IOM Committee, and Academic Medicine have significant common ground:

Advancing GME Accountability
IOM Committee’s Assessment and Rx: AAMC agrees with key points

✓ Physician training needs long-term, stable $.

✓ Nation needs training that achieves comprehensive, coordinated, capable care.

✓ Other factors – e.g., patient care payment – will have more impact on direction of future health care than Medicare GME $.

✓ There’s room for improvement in accountability – academic medicine is committed:
  - In principle and in most of the details MedPAC recommends.
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<td>• Establish performance-based GME initiative – redirect 50% of Medicare IME for performance-based system.</td>
<td>• Place up to 2% of Medicare IME at risk if hospitals fail to meet performance standards established by DHHS.</td>
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<td>• DHHS should set standards on practice-based learning, etc.</td>
<td>• Direct DHHS to set patient care priorities.</td>
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<td>• DHHS should publish annual report on hospitals’ use of Medicare GME.</td>
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<td>• Conduct workforce analysis to determine number, type residency slots needed.</td>
<td>• Direct GAO to determine number, type of physician shortages.</td>
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<tr>
<td>• Study workforce diversity.</td>
<td>• Direct GAO to study workforce diversity.</td>
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Conclusions: We all share the same goal