INTRODUCTION

The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 (P.L. 105-33). It advises the U.S. Congress on a broad range of issues affecting the Medicare program. This policy monograph focuses just on MedPAC recommendations concerning physician workforce and graduate medical education (GME). It analyzes recommendations from several different MedPAC reports and compares them to a set of core principles on physician workforce and the financing of GME developed by ACP-ASIM. (1)

The College’s core principles are not intended to be all-inclusive. Instead, they are meant to highlight particular issues that should be addressed by policymakers as they consider proposals concerning the health professions workforce and GME. In developing these core principles, it was not expected that any particular legislative proposal or set of recommendations would address each and every one of our principles. Instead, the principles are intended to guide College policy in evaluating legislative and other public policy proposals and to serve as the basis for further College policy development.

Although the MedPAC recommendations analyzed in this monograph are contained in several different reports, the recommendations are consistent with each other and more recent recommendations generally build or expand upon earlier ones. Accordingly, the MedPAC recommendations are paraphrased and consolidated for analysis purposes and are not repeated for each report in which they appeared.

MedPAC Recommendations Concerning Physician Workforce

MedPAC maintains that Medicare’s primary purpose is ensuring beneficiary access to care and should not be used as a policy lever to achieve health workforce goals. MedPAC states that Medicare payment policy should not be used as a primary tool for affecting the overall supply, specialty mix, and distribution of health care professionals. Instead, MedPAC recommends, “Federal policies intended to affect the number, specialty mix, and geographic distribution of health care professionals should be implemented through specific targeted programs rather than through Medicare.” (2)

Accordingly, MedPAC recommended revising the way that Medicare pays for the direct cost of graduate medical education to eliminate incentives and disincentives for certain types of specialty training. In its March 2001 Report (3), MedPAC recommends,

The Congress should eliminate the weighting factors that currently determine Medicare’s direct graduate medical education payments and count all residencies equally through completion of residents’ first specialty or combined program and subspecialty if one is pursued. Residents training longer than the minimum
number of years required for board eligibility in a specialty, combined program, or subspecialty should not be included in hospitals’ direct graduate medical education resident counts. These policy changes should be implemented in a budget-neutral manner through adjustments to the per resident payment amounts.

ACP-ASIM Analysis and Policy Recommendations

ACP-ASIM has favored development of a national health workforce policy and the use of incentives to achieve national health workforce goals. The College has also favored specific targeted programs to achieve these goals in addition to use of payment incentives through the Medicare program. ACP-ASIM core principle #2 calls for a reduction in the number of residency training positions in relation to the number of U.S. graduates plus an additional amount for residency training of International Medical Graduates (IMGs), retraining, and flexibility. MedPAC does not address this. MedPAC’s recommendation not to use the Medicare to affect the specialty mix of physicians is inconsistent with and will not help achieve ACP-ASIM core principle #4, which calls for physicians to be educated and trained in proportion for a balanced mix of generalists and specialists. Likewise, MedPAC’s recommendation is inconsistent with and would not address core principle #5: The expanding roles and increasing numbers of non-physicians must be considered, and the supply of these health care professionals should also be adjusted to reflect national needs and requirements. MedPAC’s recommendation is also inconsistent with core principle #6, which calls for workforce policy to improve the geographic distribution of physicians, and specifically supports incentives to encourage all health care professionals to meet the health care needs of the underserved.

Although MedPAC does recommend that specific targeted programs should be used to achieve workforce goals, there is no assurance that Congress would enact or fund targeted programs that would effectively replace existing incentives now provided by Medicare. Discretionary grant programs would be subject to the whims of the annual federal budget process. They would not provide funding stability for residency training programs and would not ensure that once an individual enters a residency, the position could be maintained for the full number of years required for completion of training. Discontinuance of Medicare payment differentials for primary care could prompt hospitals to eliminate needed primary care residency programs because they do not generate significant revenues compared to other hospital medical and surgical services.

MedPAC specifically calls for the elimination of the weighting factors that are currently a part of Medicare’s direct GME payments, and recommends counting all residencies equally through completion of the minimum number of years required to complete training for board eligibility in a specialty, subspecialty, or combined program. However, MedPAC recommends implementing this change in a budget-neutral manner.

Medicare now provides a full direct GME payment adjustment for the training of each full-time equivalent (FTE) resident during his or her initial residency period (the minimum number of years required for board certification in the specialty a resident first enters after medical school) up to a maximum of five years and 0.5 FTE for each resident beyond their initial residency
period (e.g., subspecialty training). Exceptions are provided by statute to allow full funding for up to two additional years for training in geriatrics and emergency medicine.

Implementation of the MedPAC recommendation would remove the existing financial incentive for hospitals to maintain residency training programs in primary care (generally 3-year programs), geriatrics, and emergency medicine. The recommendation to implement these changes in a budget-neutral manner would mean that Medicare per resident payments for direct GME costs for these programs, as well as other programs that are for less than five years, would be reduced to offset the additional costs of expanding the number of programs eligible for full Medicare funding of direct GME costs. However, it would benefit training in subspecialties, such as cardiology, oncology, and gastroenterology that now receive full funding for the three years required for certification in internal medicine (the initial residency period), but only 0.5 FTE for each of the additional three years required for subspecialty certification. For these and other subspecialty programs, Medicare would provide full funding for all years of training required for initial subspecialty board eligibility.

ACP-ASIM core principle #1 states that all health care payers should share in the costs of graduate medical education. MedPAC does not address this issue, because its charge is confined to the Medicare program. However, in the absence of an all-payer funding stream for GME, Medicare is the single most influential payer that explicitly recognizes GME costs in its payment policy. This is a powerful lever for influencing the supply and distribution of the nation’s health professions workforce. Removing this lever without commensurately powerful alternatives will undermine efforts to achieve a better balance between physician generalists and specialists or to achieve more appropriate numbers and distribution of other health professionals.

Eliminating current differentials in funding the direct costs of GME that now favor primary care programs and expanding funding for some subspecialty programs and combined programs without regard to workforce needs would not necessarily facilitate implementation of ACP-ASIM core principle #4 that “physicians be educated and trained in proportion for a balanced mix of generalists and specialists.” On the other hand, by improving funding for subspecialty and combined programs, the recommendation could help sustain these training programs and better assure that the medical profession and teaching institutions remain the ultimate decision-makers regarding the type of training programs that are provided.

**MedPAC Recommendations Concerning GME Financing**

MedPAC has issued several recommendations for changes in Medicare policy concerning payment for physician services at teaching hospitals and other GME training sites. Specifically, MedPAC has recommended that:

- Medicare should pay more for patient care in all settings where residents and other health care professionals train when the enhanced value of that care justifies its higher costs;
- Diagnosis related groups should be improved to reflect more accurately the relationship between illness severity and the cost of inpatient care; and
Medicare’s payments should be revised to recognize the higher value of patient care services provided in teaching hospitals through an enhanced patient care adjustment that should be phased-in. (2)

In its June 2000 Report (4), MedPAC further recommended that:

Congress should fold inpatient direct graduate medical education costs into prospective payment system payment rates through a revised teaching hospital adjustment. “The new adjustment should be set such that the subsidy provided to teaching hospitals continues as under current long-run policy. This recommendation also should be implemented with a reasonable transition to limit the impact on hospitals of substantial changes in Medicare payments and to ensure that beneficiaries have continued access to the services that teaching hospitals provide.

The MedPAC recommendations are premised on the belief that “payments to teaching hospitals for the direct costs of operating approved medical residency programs should be viewed as payments for patient care, not as payments for training.” (2) MedPAC asserts that residents incur much of the costs of their own training by accepting lower wages than they otherwise could receive in a competitive market. Resident stipends and other education-related costs currently incurred by hospitals could then be represented as the enhanced value of patient care that residents provide. Accordingly, MedPAC recommends combining current payments for direct and indirect GME costs into one payment (Enhanced Patient Care Adjustment) that would better account for the higher costs of care provided to Medicare beneficiaries at teaching hospitals. This adjustment would then be applied to Medicare DRG payments per case. MedPAC maintains that an appropriately designed payment adjustment for enhanced patient care along with certain technical refinements “would help ensure access to the services that teaching hospitals provide while simultaneously encouraging teaching hospitals to provide services efficiently.” (2)

MedPAC has stated that its recommendations concerning Medicare GME payments are not intended to achieve budget savings, but are to improve the accuracy of overall Medicare payment policy. By replacing current direct GME hospital-specific per resident amounts and including IME adjustments under the prospective payment DRG system, MedPAC seeks to remove much of the variation in Medicare’s payments to teaching hospitals and make payments consistent with the costs of an efficient provider.

ACP-ASIM Analysis and Policy Recommendations

ACP-ASIM core principle #8 states: Funding for GME should be sufficient, predictable, and stable to support the academic, patient care, and research missions of teaching hospitals and ambulatory training sites, including disproportionate share hospital (DSH) costs for care of indigent and under-insured patients. (2)

Although the MedPAC goals of making payments consistent with the costs of an efficient providers and minimizing variation in payments among teaching hospitals may be responsive to directives from Congress, they are not consistent with the above ACP-ASIM principle. ACP-ASIM and almost 50 other medical organizations, including the AMA, the American College of
Surgeons, and many other specialty and subspecialty societies, have expressed significant concerns about the MedPAC proposals and their potential impact on residency training. (5) There is particular concern that at a time when teaching hospital total margins are the lowest of any major hospital group, the proposed reductions in Medicare GME funding would threaten the very existence of some institutions and cause substantial disruptions for hospitals, medical schools, and physicians-in-training. Data gathered by the AAMC Council of Teaching Hospitals, as well as data from MedPAC, show steep declines in the operating margins of teaching hospitals in 1997, 1998, and 1999, indicating deteriorating financial conditions for major teaching hospitals. (6)

Separating the costs of education and training from the costs of patient care has always been problematic, if not impossible, since residency training is interwoven with hands-on provision of patient care by residents under the supervision of teaching faculty and more experienced residents. Furthermore, even if the educational component of patient care could be isolated and paid under the Medicare Prospective Payment System, there would be substantial payment reductions for teaching hospitals. One estimate of the impact of the MedPAC proposals was that $1.5 billion would be removed from Medicare GME payments.

Current indirect GME payments reflect recognition that there are other costs associated with patient care at teaching facilities. These include the higher costs of treating patients with more severe and complex illnesses, providing access to care for uninsured and low-income patients, the costs of clinical research and the technology and other facilities required for research, and higher costs from more frequent use of diagnostic tests ordered as part of training, and the costs of providing regional and standby services on a 24 hour/7 day basis. Since the inception of the Medicare program, Congress, HCFA, the Congressional Budget Office, General Accounting Office, and various commissions and advisory groups, as well as health services researchers, have struggled to better quantify the additional costs of teaching programs. Paying an adjustment for only those additional costs that can be explicitly quantified, will force teaching hospitals to absorb greater unfunded costs. By asserting that residents bear much of the costs of their own GME and training, MedPAC implies that the Medicare program does not need to fully fund its share of the costs. This would mark a major curtailment of Medicare’s commitment to help fund GME and to assure that an appropriately trained and qualified physician workforce is available and accessible for Medicare beneficiaries.

MedPAC has recognized that its recommendations could have serious repercussions on the nation’s teaching hospitals. It therefore recommended that its proposal for a revised teaching hospital adjustment be implemented with a reasonable transition to limit the impact on hospitals and ensure that beneficiaries have continued access to the services that teaching hospitals provide. This is consistent with ACP-ASIM’s core principle concerning stable and predictable funding.

ACP-ASIM supports MedPAC proposals to pay more for patient care in settings where residents and other health care professionals train and to improve Medicare payments to reflect more accurately the relationship between illness severity and the cost of inpatient care. However, the College cannot support the MedPAC proposals as a package, including paying only for the
quantifiable value of “enhanced patient care,” because of the potential for substantially reducing overall financial support for GME and harming teaching hospitals.

SUMMARY

MedPAC’s position that Medicare payment policies should not provide incentives or disincentives for affecting the supply, specialty mix or geographic distribution of health care professionals is at odds with ACP-ASIM’s core values that physicians should be educated and trained in proportion for a balanced mix of generalists and specialists and that the roles and increasing numbers of non-physicians should be considered and adjusted to reflect national needs and requirements. Although the College also would prefer specific targeted programs to achieve workforce goals, there is no assurance that if existing incentives now provided through Medicare were ended, they would be fully replaced or that programs subject to the annual federal budget appropriations process could provide stable funding required for residency training. However, MedPAC’s recommendation to eliminate current differentials in funding the direct costs of graduate medical education (DGME) would result in decreased Medicare funding for primary care residencies, but would benefit some subspecialty and combined residency programs.

ACP-ASIM supports some of the MedPAC recommendations for financing GME but cannot support the recommendations in their entirety because of the potential for substantially reducing overall financial support for graduate medical education and harming teaching hospitals. ACP-ASIM supports MedPAC efforts to improve the Medicare Prospective Payment System to have payments better recognize the higher costs of patient care in teaching settings. However, separating and appropriately reimbursing teaching hospitals and ambulatory training sites for the “enhanced value of patient care” is seen as problematic, if not impossible. ACP-ASIM believes that all payers should share in the costs of graduate medical education. Absent adoption of an all-payer system, ACP-ASIM is concerned that adoption of the MedPAC recommendation to combine current payments for the direct and indirect costs of graduate medical education into one payment with an enhanced patient care adjustment would result in substantial and harmful reductions in funding for GME. MedPAC recognizes that its proposed changes would be disruptive and therefore advises that the changes be implemented with a reasonable transition to limit their impact. Although this would be more consistent with ACP-ASIM’s core principle that funding be sufficient, predictable, and stable to support the multiple missions of teaching hospitals and ambulatory training sites, overall the College finds the MedPAC recommendations to be inconsistent with this core principle.
## ACP-ASIM Core Principles on Workforce and GME

1A) Undergraduate class size and the total number of students graduating from U.S. medical schools should reflect national needs and requirements for physicians.

1B) Total enrollment in U.S. medical schools should be reduced, and there should be no net increase in the number of allopathic or osteopathic medical schools.

2) All health care payers should share in the costs of graduate medical education.

3) The number of residency training positions should be reduced and related to the number of U.S. graduates plus an additional amount for IMGs, retraining, and flexibility.

4) Physicians should be educated and trained in proportion for a balanced mix of generalists and specialists.

5) The expanding roles and increasing numbers of non-physicians must be considered, and the supply of these health care professionals should also be adjusted to reflect national needs and requirements.

6) Workforce policy should improve the geographic distribution of physicians. Incentives should encourage all health care professionals to meet the health care needs of the underserved.

7) There should be no discrimination for career opportunities in medicine.

8) Funding for GME should be sufficient, predictable, and stable to support the academic, patient care, and research missions of teaching hospitals and ambulatory training sites, including DSH costs for indigent and under-insured.
## COMPARISON OF MEDPAC RECOMMENDATIONS TO ACP-ASIM CORE PRINCIPLES

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<td>The costs of care for all poor patients should be included in calculating DSH payments and the threshold, for the low-income share that a hospital must have before DSH payment is made should be set to make 60 percent of hospitals eligible. (March 2000)</td>
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REFERENCES


5. Coalition Letter (signed by 48 organizations) to Gail Wilensky, PhD, Chair MedPAC, April 12, 2000.

GLOSSARY OF KEY TERMS and ACRONYMS

**Budget neutral**: In federal budget parlance, this means that a change will have no net difference in federal budget spending than would have occurred if the change had not been enacted. Thus, outlays for a given budget item remain as they would have been under the previous budget including projected growth for inflation, and not necessarily the same dollar amount as the previous year.

**Council on Graduate Medical Education (CoGME)**: An advisory body established by Congress “to provide an ongoing assessment of physician workforce trends, training issues and financing policies, and to recommend appropriate Federal and private sector efforts to address identified needs.” Authorizing legislation calls for CoGME to advise and make recommendations to the Secretary of the Department of Health and Human Services, the Senate Committee on Labor and Human Resources, and the House of Representatives Committee on Commerce.

**Diagnosis Related Group (DRG)**: A system used by Medicare and other insurers to classify illnesses according to diagnosis and treatment. DRGs reflect expected lengths of stay and predetermine hospital reimbursements.

**Direct Cost of Graduate Medical Education (DGME)**: Medicare pays for its share of expenses directly attributable to the costs of a operating an approved graduate medical education program. Payments are intended to cover the costs of resident’s salaries, compensation for teaching faculty and supervision, and associated overhead costs, such as the cost of classrooms and educational materials. Payment is based on the number of residents, a hospital-specific per resident amount based on 1984 costs updated for inflation, and Medicare’s share of hospital inpatient days. Residents training at ambulatory care sites are included in the hospital resident count if the hospital assumes substantially all of the training costs. Effective January 1, 1998, Medicare may make DGME payments to “non-hospital provider entities” (ambulatory settings) for residents in approved GME programs.

**Disproportionate Share Hospital (DSH) payment adjustments**: Certain hospitals receive an additional Medicare payment because they treat a large number of poor Medicare or Medicaid patients. Different formulas are used to establish a hospital’s DSH threshold and payment adjustment, depending on the hospital’s location, number of beds, and status as a rural referral center or sole community hospital.

**Generalist Physicians**: The term, as used by the Council on Graduate Medical Education (CoGME) and the Bureau of Health Professions, to indicate physicians trained in the primary care disciplines of general internal medicine, family medicine, and general pediatrics. The distinction is made that these physicians provide first contact care for patients with undifferentiated health concerns as opposed to “Specialists” and “Subspecialists,” who provide non-primary care but also provide a significant amount of primary care.
Graduate Medical Education (GME): Medical training in an approved program of residency training involving the provision of patient care under supervision with progressively greater individual responsibility for patient care management.

Health Care Financing Administration (HCFA): The agency that administers federal funds for the Medicare and Medicaid programs.

Indirect Medical Education (IME) adjustment: The IME adjustment is applied to Medicare payments based on diagnosis related groups (DRGs) under Medicare’s Prospective Payment System (PPS). For operating costs, the adjustment is based on the hospital’s ratio of interns and residents to the number of beds. For capital costs, it is based on the hospital’s ratio of interns and residents to average daily attendance. The IME adjustment is intended to reflect higher patient care costs associated with teaching programs for specialized care for more complex cases, the costs of additional tests and services ordered by residents, costs of research, as well as other costs associated with teaching programs.

Initial Residency Training Period: The minimum number of years required for completion of an approved program of graduate medical residency training, generally 3 years, but can be as much as 6 years. For Medicare funding purposes, the initial residency training period is the number of years required for an individual resident to become eligible to take his or her first board certification examination in the specialty he or she first began.

International Medical Graduate (IMG): A doctor who is a graduate of a medical school outside the United States that is not accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association.

Medicare Payment Advisory Commission (MedPAC): An independent federal body established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise Congress on a broad range of issues affecting the Medicare program, particularly payment issues.

Prospective Payment System (PPS): The payment system used by Medicare in which rates are determined in advance based on DRGs.

Specialist Physicians: The term, as used by the Council on Graduate Medical Education (CoGME) and the Bureau of Health Professions, to indicate physicians who receive subspecialty training and training in non-primary care disciplines. It refers to both “specialists” and “subspecialists,” who provide non-primary medical care but who also may provide a significant amount of primary care.