ACP American College of Physicians℠
INTERNAL MEDICINE | Doctors for Adults

Federal Programs and Legislation Addressing Physician Workforce Shortages
Leadership Day on Capitol Hill
May 21-22, 2013

Background

Where Things Stand

According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of more than 90,000 physicians by 2020; about half of the shortage will be in general surgery and medical specialties, while the other half will be in primary care. Increasing graduate medical education funding and using such funding more strategically are essential toward addressing the physician workforce crisis. In addition, funding for federal programs aligned to improving the primary care workforce and ensuring access to a primary care physician must be preserved.

More than 100 studies show that increased availability of primary care in a community is positively associated with lower costs and better outcomes of care. Yet the United States is facing a growing shortage of primary care physicians for adults—including internal medicine specialists who provide a substantial portion of primary care for millions of Medicare and Medicaid enrollees. Other physician specialties, including many internal medicine subspecialties, also are facing shortages.

Medical students who enter internal medicine residencies are choosing to subspecialize at increasing rates and of those who stay within general internal medicine a significant portion are choosing hospitalist care over office-based practice. With our population aging and chronic conditions increasing, we need to be providing the public with more, not fewer physicians trained to take care of their health care needs. In 2010, the Council on Graduate Medical Education (COGME) told Congress that in order to have an adequate supply of primary care physicians we need to increase their ratio to 40 percent of all physicians, an 8 percent increase over what was at the time 32 percent.

A study published in *The Journal of the American Medical Association* (*JAMA*) in December 2012 shows that at the rate that medical students and residents are currently choosing general internal medicine there will not be enough internal medicine specialists in primary care fields to care for all of the patients who need them. In 2012, only 21 percent of third-year internal medicine residents intended to pursue careers in general internal medicine, down from 54 percent in 1998. Even more disheartening, only 18 percent of first-year internal medicine residents intend to pursue general internal medicine. An accompanying editorial in the same issue of *JAMA* pointed to the COGME report from 2010 and noted that even if half of all internal medicine residents were to choose general internal medicine, we would still be falling well short of the recommended increase in primary care. The solution to this problem must address both attracting medical students into primary care and retaining primary care physicians once they enter the field.

Background

THE NATIONAL HEALTH SERVICE CORPS (NHSC)

This federal program is vital in that it addresses the supply of primary care physicians for adults, which is dwindling while the demand for primary care is expected to grow at a rapid rate. The NHSC provides scholarships and loan forgiveness to enable primary care physicians to be trained to serve underserved communities. The program receives mandated dedicated funding from the Affordable Care Act (ACA).

The College urges $893,456,433 in appropriations for the NHSC for FY2014, which begins on October 1, 2013 and ends on September 30, 2014, and is the amount authorized for FY2014 under the ACA; this is in addition to the $305 million in enhanced funding the Health and Human Services Secretary has been given the authority to provide to the NHSC through the Community Health Care Fund created by the ACA. Since enactment of the ACA, the NHSC has awarded over $900 million in scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of communities across the country. There are nearly three times the numbers of NHSC clinicians working in communities across America than there were three years ago, increasing Americans' access to health care. With field strength of nearly 10,000 clinicians, NHSC members are providing culturally competent care to

more than 10.4 million people at nearly 14,000 NHSC-approved health care sites in urban, rural, and frontier areas. The programs under the NHSC have proven to make an impact in meeting the health care needs of the underserved, and with more appropriations, they can do more.

TITLE VII HEALTH PROFESSIONS

Within the Title VII Health Professions program, ACP urges $71 million for FY2014, which begins on October 1, 2013 and ends on September 30, 2014, to fund the program the Section 747, Primary Care Training and Enhancement, in order to maintain and expand the pipeline of primary care production and training. The recommended funding level for the Section 747 program was determined by a multi-stakeholder process involving organizations and other experts that assess the resources required for the program to achieve its objectives, recognizing today's very tight fiscal environment. The Section 747 program is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine. For example, general internists, who have long been at the frontline of patient care, have benefitted from Title VII training models that promoted interdisciplinary training that helped prepare them to work with other health professionals, such as physician assistants, patient educators and psychologists. With the grant dollars, residency programs are able to fund new initiatives relating to increased training in inter-professional care, the patient-centered medical home, and other new competencies required in our developing health system.

GRADUATE MEDICAL EDUCATION (GME)

GME is a formal clinical training provided by approved residency and fellowship programs to physicians who have received an MD or a DO degree (or a foreign equivalent). It involves a period of training lasting at least three to seven years in which physicians are directly supervised in their learning as they progressively assume more responsibility for patient care.

GME is a public good—it benefits all of society, not just those who directly purchase or receive it. The federal government recognizes the importance of supporting medical education and is the single largest explicit contributor to GME. Funding is primarily provided through the Medicare program, which subsidizes education and training for over 90,000 residents in more than 1,100 hospitals. The number of federally funded GME positions were capped in 1997and this limit has remained in place ever since, though there have been some exceptions that have allowed for some minor growth. Other forms of government support come through state Medicaid programs, the Department of Defense or the Department of Veterans Affairs. In addition to government funding, private payers, philanthropy, and institutional resources may provide support.

With the federal deficit at an all-time high and an increased commitment to fiscal responsibility, entitlement programs, such as Medicare, face greater scrutiny. There has been an increased interest in transparency and accountability for the nearly $10 billion that the federal government spends on GME annually.

The costs of GME are recognized by Medicare under two mechanisms: (1) direct graduate medical education payments (DGME) to hospitals for residents' stipends, faculty salaries, administrative costs, and institutional overhead, and (2) indirect medical education (IME) adjustment developed to compensate teaching hospitals for the higher costs associated with teaching, the involvement of residents in patient care, and the severity of illness of patients who require the specialized services that are available in teaching hospitals. Because the results from IME payments are not as concrete as DGME payments, since the amount is tied to a hospital's Medicare inpatient volume and case mix along with their training program size (subject to their resident cap number), more scrutiny is being given to IME payments. The Medicare Payment Advisory Commission (MedPAC) has consistently found that the IME payments teaching hospitals receive are higher than the actual cost of treating Medicare patients. MedPAC studied Medicare inpatient costs per case and found that costs increased about 2.2 percent for every 10 percent increase in the ratio of residents to hospital beds, less than half the current IME adjustment of 5.5 percent. MedPAC and some legislators have proposed using the "excess" funds to develop a performance based GME payment system. Several deficit reduction proposals have cited the MedPAC study and proposed IME cuts ranging from 2 percent to 60 percent.

In his FY2014 budget request, President Obama also called for an $11 billion reduction of IME payments, citing the afore mentioned MedPAC study. His proposal would reduce IME payments by ten percent, beginning in 2014. In addition, the Secretary would have the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage training of primary care residents and emphasize skills that promote high-quality and high value health care delivery. ACP is not supportive of the proposal, and believes that GME funding should be preserved so that training programs can develop the most robust programs and meet the requirements stipulated by their Residency Review Committees (RRCs). However, the College acknowledges that there needs to be more transparency and accountability to ensure funds are appropriately designated toward activities related to the educational mission of teaching and training residents with the skills and experiences necessary to meet the nation's health care needs.

The federal government's vital investment in training physicians also is threatened by an automatic two percent across-the-board cut in Medicare program payments to physicians and hospitals, including Medicare GME payments, as a result of the "sequester" mandated by the Budget Control Act of 2011. The sequestration cut took effect on April 1, 2013. ACP has strongly urged Congress to reverse across-the-board sequestration cuts and preserve funding for essential health programs such as Medicare GME by adopting alternative measures addressing the true cost drivers that are responsible for rising health care costs. The AAMC estimates the Medicare GME sequestration cut will result in the "average major teaching hospital having nearly $14 million less to support critical patient care services they provide in their communities."

As outlined in ACP's recent paper entitled, *Aligning GME Policy with the Nation's Health Care Workforce Needs*, ACP makes the following key recommendations to Congress.

- GME financing should be transparent, and all payers should be required to contribute to a financing pool to support residencies that meet policy goals so that the costs of GME financing are spread across the health care system.
- Payment of Medicare GME funds to hospitals and training programs should be tied to the nation's health care workforce needs and place a priority on primary care in order to create a well-functioning health care system.
- GME caps should be strategically lifted, as needed, to permit training of an adequate number of primary care physicians, including general internists, and other specialties facing shortages.

As discussed below, several bills have been introduced that address the need to increase funding for GME and to strategically lift the caps on GME residency positions, particularly for primary care specialties.

VISA PROGRAMS FOR INTERNATIONAL MEDICAL GRADUATES

The College has long recognized the value of international medical graduates (IMGs) and their contributions to health care delivery in this country. ACP supports streamlining the process for obtaining J-1 and H1B visas for non-U.S. citizen international medical graduates who desire postgraduate medical training and/or medical practice in the U.S. ACP supports the expansion of J-1 visa waiver programs, such as Conrad 30, to help alleviate physician shortages in underserved urban and rural areas; this program should also be made permanent. ACP supports the exemption of physicians trained in specialties that are facing shortages in the United States from the annual H-1B visa cap. Specific legislative initiatives supported by ACP regarding IMGs can be found below.

For further information, please read ACP's policy paper entitled *National Immigration Policy and Access to Health Care.*

OTHER FEDERAL PROGRAMS AFFECTING THE PHYSICIAN WORKFORCE

The Affordable Care Act initiated several programs which are impacting the physician workforce; those of note are highlighted below.

Redistribution of Residency Slots: The Centers for Medicare and Medicaid Services (CMS) was required to take 65 percent of the DGME and IME residency slots that have gone unused by a hospital for the past three years and to redistribute them according to certain criteria. The DGME and IME resident caps of hospitals with three years of unused

residency slots were permanently reduced beginning July 1, 2011. In 2011, CMS announced that it has redistributed roughly 1,354 Medicare residency positions. The 628 indirect medical education and 726 direct graduate medical education positions were allocated to 58 qualifying hospitals from 267 hospitals that were not training up to their residency caps. In accordance with the ACA redistribution formula, 70 percent of the positions were allocated to 39 hospitals in states with resident-to-population ratios in the lowest quartile, and 30 percent were allocated to 19 hospitals in rural or health professional shortage areas.

Teaching Health Centers (THC): As established and authorized in the ACA, the THC program provides grants and Graduate Medical Education funding to THC to train primary care physicians in community-based, ambulatory patient care settings. The THC development grants can be used for activities associated with establishing or expanding a primary care residency training program including curriculum development, faculty and trainee recruitment, training, retention, and accreditation. Since 2011, twenty-one THC have received grant dollars, ensuring residents are able to train in community-based settings.

Medicare primary care bonus: In calendars years 2011-2015, the ACA provides a 10 percent bonus payment on select primary care services furnished by primary care physicians. To qualify for the bonus, a physician must be self-designated in a primary care specialty, defined as general internal medicine, family practice, geriatrics, and pediatrics, and he or she must predominantly provide select primary care services to be eligible. For more in depth information, including eligibility and the impact on your practice, please see the backgrounder entitled *The Affordable Care Act at Age Three*.

Enhanced Medicaid Reimbursement Rates for Primary Care Services: The ACA includes a provision to increase Medicaid payment rates for certain primary care services to at least the level of Medicare in calendar years 2013 and 2014. Often referred to as the Medicaid pay parity provision, this initiative provides for higher Medicaid payments to physicians practicing a specialty designation of family medicine, general internal medicine or pediatric medicine. For more in depth information, including eligibility and state-specific information, please see the backgrounder entitled *The Affordable Care Act at Age Three*.

National Health Care Work Force Commission: The ACA establishes the Commission, a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy beginning in 2010. Unfortunately, Congress has yet to fund the Commission so it has not yet convened. For more in depth information about the Commission, please see the backgrounder entitled *The Affordable Care Act at Age Three*.

ACP-ENDORSED LEGISLATION OR INITIATIVES

There are several bills which ACP supports that would address the physician workforce shortage, with an emphasis on primary care. Those of note include:

- ***The Resident Physician Shortage Reduction Act*** **(S. 577 and H.R. 1180),** introduced in the Senate by Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) and in the House by Representatives Joseph Crowley (D-NY) and Michael Grimm (R-NY), will increase the number of Medicare-supported training positions for medical residents who choose careers in primary care. Specifically, the bill will provide for approximately 15,000 additional GME positions for medical residents. It will require at least 50 percent of the new positions to be allocated to specialties such as primary care that are currently facing a shortage. The current Medicare GME funding limits on residency training positions are impeding the establishment of new residency programs and additional training positions in existing programs. Increasing the overall pool of physicians will not assure that adequate numbers enter and remain in practice in primary care (general internal medicine, family medicine, and pediatrics). Instead, a more targeted approach is needed, as S. 577/H.R. 1180 strives to do, recognizing the nation's increasing demographic demands for health care, by strategically increasing the number of Medicare-funded GME positions in adult primary care specialties.

- ***Training Tomorrow's Doctors Today Act*** **(H.R. 1201),** introduced in the House by Representatives Allyson Schwartz (D-PA) and Aaron Schock (R-IL), authorizes the Secretary of Health and Human Services to increase

the number of GME slots by 15,000 over the next five years, providing additional opportunities for residents who choose careers in primary care or general surgery as it mandates that any hospital that receives funding for additional residency positions shall ensure that not less than 50 percent of the new slots are used to train residents in primary care or other residents in specialties facing shortages.

H.R. 1201 would also establish and implement procedures under which payment for indirect medical education is adjusted based on the reporting of quality measures of patient care specified by the Secretary of Health and Human Services. ACP believes that the concept of a performance based GME payment system is worth exploring but cautions such a system must be thoughtfully developed and evaluated with input from a variety of stakeholders including physicians involved in primary care training.

- ***The Primary Care Workforce Access and Improvement Act* (H.R. 487),** introduced in the House by Representative Cathy McMorris Rogers (R-WA), authorizes the Secretary of Health and Human Services to conduct a five year Medicare pilot project that would direct a share of Graduate Medical Education funding to medical education entities to test different models of primary care training. This bill gives the HHS Secretary the authority to test new models of care that demonstrate the capability of improving the quality, quantity, and distribution of primary care physicians. Improved models of ambulatory training and exposure to team-based approaches to patient care, such as the patient centered medical home, are essential to making careers in general internal medicine and other primary care specialties more attractive and relevant.

- ***The Conrad State 30 and Physician Access Act*** (S.616), introduced in the Senate by Senator Amy Klobuchar (D-MN), permanently reauthorizes the Conrad 30 State J-1 Visa Waiver program and makes improvements to the immigration laws affecting IMGs outside of the Conrad 30 program with the same goal of increasing access to physicians in underserved communities. For example, IMGs would be eligible for a National Interest Waiver green card if they serve for 5 years in a medically underserved area or Veterans Affairs medical facility. The bill would also exempt these physicians from the worldwide cap on employment-based green cards (e.g., H-1B visas).

  On a related note, on April 17, a bi-partisan group of Senators introduced S.744, the *Border Security, Economic Opportunity, and Immigration Modernization Act*, a comprehensive immigration reform bill. While the College does not have policy on the overall immigration issue or the bill itself, ACP does have policy stating that (1) there should be a national solution to the immigration problem and (2) any immigration legislation enacted by Congress should include changes in visas as they affect IMGs (noted in the preceding paragraph). Sen. Klobuchar's legislation, S. 616, has largely been incorporated into S. 744.

For more information on ACP's positions on workforce issues, please visit the Advocacy section of ACP Online, http://www.acponline.org/advocacy/where_we_stand/workforce.html.