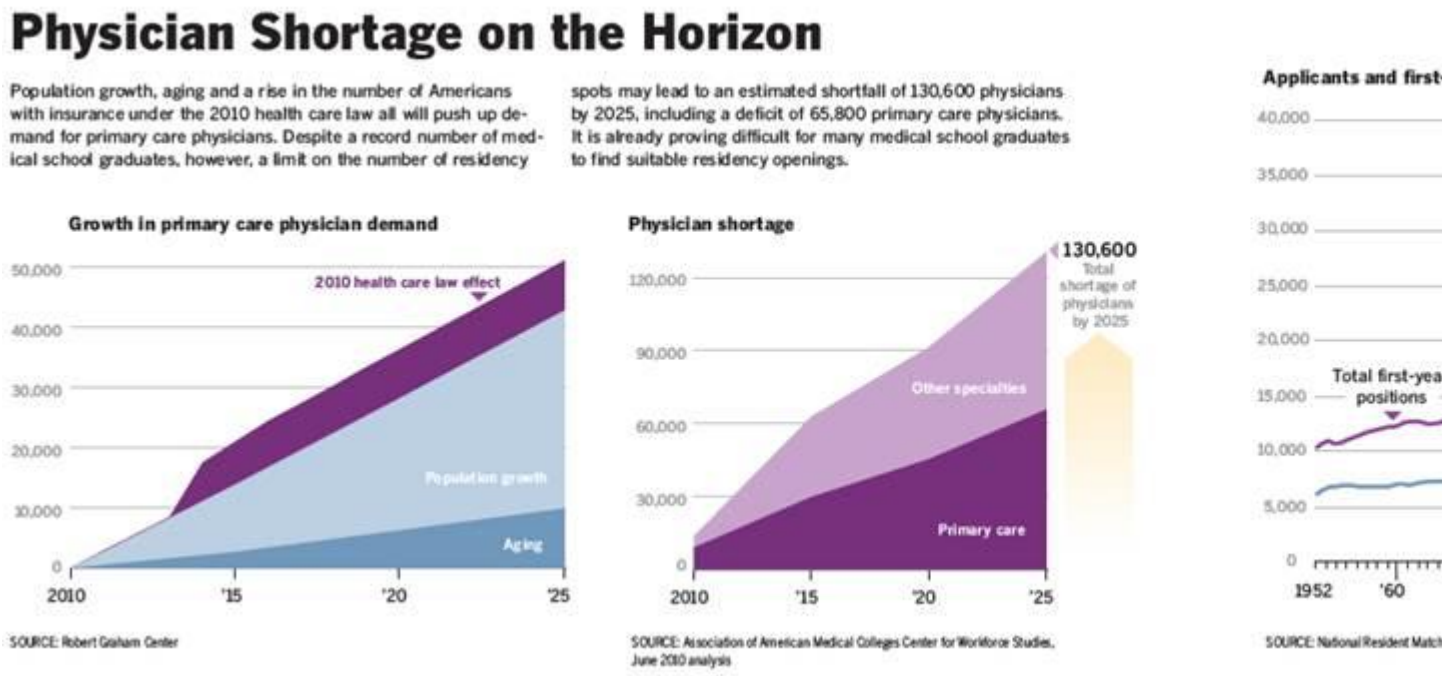
The Doc Cap

By Melissa Attias, CQ Staff

Two trends are expected to drive U.S. health care policy in coming years. America's population is aging rapidly, to the tune of 10,000 new Medicare enrollees every day. And at the same time, the 2010 health care law will extend access to doctors and hospitals to millions of people under 65, many of whom have never before stepped into an exam room. Both groups will clamor for health services and benefits that are likely to be increasingly constrained.



The nation faces a projected shortage of more than 90,000 physicians by 2020, according to the Association of American Medical Colleges. It's a plainly serious problem that may grow to crisis proportions. And it isn't the result of too few slots in medical schools. The number of potential physicians enrolling in med school is rising rapidly. The bottleneck occurs at the point where graduates learn to treat patients in the real world. Students who want to go into practice complete residencies that give them advanced, postgraduate training and experience, under the supervision of physicians and hospitals. Some residencies may last for several years, depending on the specialty.

But there is little movement to find the relatively small amount of money needed to boost the number of slots for medical residents. Just the opposite, in fact, is the case. Existing federal support for medical residencies has been targeted for cuts by bipartisan budget hawks and by President Barack Obama.

Advocates for medical schools and some lawmakers contend that, to the contrary, more federal support is needed and that it's irresponsible to preserve a 1997 law that caps the number of residency slots that receive crucial funding through Medicare. Hospitals on their own don't have the money to prepare a sufficient number of beginning doctors, these advocates say.

"What we have is two responsible parties," says Democratic Rep. Joseph Crowley, whose home state of New York trains more doctors than any other state. "We have the medical schools, which are doing their part by expanding the opportunities for medical education. But the government is the other responsible party. We haven't raised the cap on the number of slots for the post-medical-school training that's required for doctors to become doctors."

It's a complex issue, driven at the outset by demand and supply. Many older people signing up for Medicare will have expensive chronic conditions that need treatment. And even as those aging baby boomers are expected to have multiple health care needs, the 25 million Americans projected to gain coverage under the 2010 health care overhaul only add to the equation. Moreover, health professionals themselves, as a group, are growing older and entering retirement.

The AAMC announced Oct. 24 that a record number of people applied to and enrolled in U.S. medical schools this year — and eventually will seek residency slots that aren't increasing at the same rate. Creating 15,000 new slots over five years would cost Medicare $9 billion over a decade, according to an estimate by the AAMC. However small that price tag might appear alongside many other federal programs, any additional spending is suspect at a time when Congress is engaged in fiscal belt-tightening.

There are other views about how to address the potential for a serious physician shortage. Some observers say the answer lies in educating more physician assistants and nurses to share the load. It would also require removing barriers that bar some health care professionals from practicing to the full extent of their education and training. That might, for instance, include allowing nurse practitioners to write prescriptions and see patients without a doctor's supervision.

Some observers also say that merely lifting the cap on Medicare-financed residencies might not produce the types of doctors the country really needs. In particular, these critics of raising the cap worry that a need for additional family practice physicians won't be met.

And there's a separate school of thought, particularly among academics, that the shortage might not come to pass, given the ways Medicare payment models are evolving. Even groups that are preparing for a shortage say the projections aren't an exact science.

"There's so much that we don't know," says Suanna Steeby Bruinooge, director of research policy at the American Society of Clinical Oncology, at an Oct. 24 briefing.

A Fundamental Notion

Medicare's role in providing money for doctor residency training, known as graduate medical education, dates to the program's inception in 1965.

In its committee report on the bill to create Medicare, the House Ways and Means Committee said the program ought to pay a portion of the cost of educational activities, such as stipends for trainees and pay for professors, at least until the medical and educational community found other ways to finance them. "Educational activities enhance the quality of care in an institution," the lawmakers wrote.

Humayun J. Chaudhry, president of the Federation of State Medical Boards, says there was concern at the time about having enough physicians to provide the level of care promised by the new program. Before Medicare was enacted, there weren't enough residency programs, and a "patchwork of funding sources" provided the support for those that did exist, he says.

But by 1980, the environment had shifted. The Graduate Medical Education National Advisory Committee was predicting a surplus of 70,000 physicians by 1990 and recommended that medical schools reduce their new class sizes. Projections about an oversupply of doctors continued through the 1990s, with Congress passing legislation to cap Medicare-supported residency slots in 1997 as part of a broad deficit reduction law.

"There was a real fear on the part of experts, the majority of experts," says Chaudhry, "that by the time the turn of the century would come around, that there'd be a surplus of physicians." According to Chaudhry, whose group represents the nation's state medical and osteopathic licensing boards, "when the Balanced Budget Act was proposed and the caps were promoted, it was a difficult subject to argue against because of that demographic data."

Atul Grover, chief public policy officer for the AAMC, also says the cap was shaped by deficit reduction efforts and the rise of managed care organizations.

The expectation, Grover says, was that fewer physicians would be needed in the future because HMOs were going to change the structure of the U.S. health care system. HMOs were designed to control costs by requiring a patient to have a primary care provider who would deal with most of the patient's care. Specialists would be seen only with a referral.

"It never turned out that way, but it really did look as if you were going to have this sweeping change in health care," Grover says.

Projections shifted dramatically over the past decade from too many physicians to too few. Responding to the new estimates, the AAMC recommended a 30 percent increase in medical school enrollment by 2015. Last month, the group said that goal was on track to be met by about 2017. But for those students to practice, Grover says, they need a residency.

“The No. 1 issue is, we’re not increasing the number of doctors we’re training, even though we’re expanding medical school enrollment, and that’s a problem because we’re not going to have enough physicians out there to take care of a lot of elderly people,” Grover says. “Are you possibly going to not be able to train physicians who have just invested four years and $200,000 into a medical degree?”

Who Should Pay?

Advocates for lifting the cap on graduate medical education slots financed through Medicare have made that one change a priority. Medicare is the single largest contributor to physician training, although federal programs and hospitals themselves help foot the tab.

According to Grover, about 10,000 residency positions above the cap are being maintained with money from teaching hospitals, but AAMC doesn’t think those extra spots are sufficient to cover the demand. Moreover, he says, declining reimbursements from insurers, Medicare and Medicaid are limiting the ability of teaching hospitals to invest more in resident training.

“We’re at a point now where we’ve kind of done as much as we can, and we need a little more help,” he says.

Teaching hospitals are losing money by treating Medicare patients, says Ashley Thompson, vice president and deputy director of policy development for the American Hospital Association, citing data from the March report of the Medicare Payment Advisory Commission, an independent body that advises Congress on Medicare policy. Thompson says hospitals face layers of cuts from recent laws at the same time that they’re trying to move from a system that pays based on volume to one that pays based on value.

“Hospitals just don’t have the resources to really continue to fund residency slots in full,” she says. “They really need the help of others to help with this public good that’s created.”

The challenge, of course, is finding a way to pay for training at a time when Capitol Hill’s focus is on reducing spending rather than creating new obligations. None of the congressional proposals includes a way to come up with the money to pay for new slots.

Republican Rep. Michael G. Grimm of New York, who introduced a bill with Crowley to raise the Medicare residency cap, acknowledges that finding the money is “obviously the toughest part.” That, he says, is the place where disagreements can most easily arise among lawmakers who agree on the overall idea of training more physicians.

Grimm says he is optimistic that lawmakers will be able to find a way to offset the increased cost before the end of this year, and he contends that maintaining the cap will end up costing money.

“What happens when you don’t have a primary care physician? You go to the emergency room, which, by the way, is three to four times more expensive than going to your primary care physician,”

he says. “This is fiscally prudent legislation. It’s absolutely necessary to avoid a major crisis.” And, he says, “this is going to save money and save lives in the long run.”

Others, though, question why Medicare pays billions of dollars to hospitals for physician training. Fitzhugh S.M. Mullan, a professor of medicine and health policy at George Washington University, concedes that a first-year resident counts as a net cost to a hospital. But, he says, after several years that person becomes a senior resident, working efficiently and fulfilling a role that the hospital would otherwise have to pay others to do.

“The notion that residents are a burden on the hospital has now really come under scrutiny,” Mullan says. He says if the number of residents does need to be expanded, then a good case can be made that the hospitals should bear the financial burden.

Solutions Abound

Beyond the debate over who should foot the bill lies another over whether raising the cap is the best way to prevent a future doctor shortage.

The American Academy of Family Physicians and other family medicine organizations are working on updating their graduate medical education recommendations in an attempt to find common ground with the AAMC, says Perry A. Pugno, vice president for education for the family practice group.

“We’ve been against simply lifting the cap because doing so would just give us more of the same — a maldistribution of specialties, a maldistribution of physicians,” Pugno says. “If you do lift the cap, it should be in a way leveraged toward what the nation needs.”

Pugno says that his group’s recommendations will be compatible with the most recent reports from the Council on Graduate Medical Education. In its August report, the council advised Congress to, among other things, finance additional training positions directed toward six “high priority specialties,” including family medicine and geriatrics.

The American Association of Colleges of Osteopathic Medicine, meanwhile, supports both lifting the Medicare cap and tying graduate medical education to areas of need such as primary care and geriatrics. President Stephen C. Shannon says his group also wants Congress to continue underwriting a program that supports primary care residency training programs in community health centers.

“That that’s another valuable way to expand the physician workforce in areas where the need is most present,” Shannon says.

Some advocates for increased availability of health care practitioners are focused on other options. One position endorsed by the senior citizen lobby AARP is that all health care professionals need to

be able to perform every task they were educated and trained to do. That means some non-physician professionals might take over some of the duties now performed by doctors.

Susan Reinhard, senior vice president and director of the AARP Public Policy Institute, says that physicians have the broadest scope of practice and that removing unnecessary bureaucratic paperwork requirements would help free them up. She also says removing requirements that physicians must supervise other health professionals would increase the time available for doctors and nurse practitioners to see patients by 10 percent.

Groups representing nurses and physician assistants are similarly pressing to remove legislative and regulatory barriers that they say limit those professionals' ability to practice.

Advanced-practice registered nurses can help fill demand in areas such as prevention and wellness, says Suzanne Miyamoto, director of government affairs and health policy for the American Association of Colleges of Nursing.

"There's a lot of opportunity here to create a more effective service," says Miyamoto, whose group warns that a nursing shortage is also expected as a consequence of the rise in demand for health care.

Shortage Forecasts Questioned

AARP supports provisions of the health care law that were designed to change the way the system is financed. But it's those very financing changes that have led to some skepticism that the projected shortages will come to pass.

New payment models that rely on teams of physicians, nurses and non-clinician workers can go a long way toward advancing the quality of care and with fewer physicians than are currently used, says Elliott S. Fisher, director of the Dartmouth Institute for Health Policy and Clinical Practice.

Anticipated physician shortages are based on the current practice models, he says, so it would be unwise to expand the residency training slots as new models for treatment are being developed.

"I think it is just as likely that we will need half as many physicians as we have now than it is that we will need more," Fisher says.

Mullan, from George Washington University, says the common wisdom is that the country will have a physician shortage. Yet he says there are probably enough doctors right now and their ranks should grow by 1 percent a year to coincide with the rate of population growth. Simply pouring more money into the current system would perpetuate problems in cost, quality and access, he says.

But in an upcoming article in Academic Medicine, the AAMC's Grover and co-author Lidia M. Niecko-Najjum argue that there's a danger of being unprepared for the population's actual needs if workforce planning is based solely on an "ideal" system. Instead, they say planning should start with the current system and make changes using data on trends as they become evident.

“The urgency of patients’ increasing health care needs combined with the long training periods required for medical professionals call for prudent action, even while attempting a complete makeover of the U.S. health care system,” they write.

Fisher also says available evidence doesn’t support the view that having more doctors leads to a higher quality of care. He says the places with more doctors have the greatest perception of scarcity because of disorganized, fragmented care. And he says health care policy needs to focus on accelerating new health care models rather than just training more doctors.

Outlook in Congress

Regardless of the debate, lawmakers on both sides of the aisle have lined up behind legislation to increase the number of Medicare-supported residency slots by 15,000 over five years. Crowley and Grimm have introduced one measure, while Reps. Aaron Schock, an Illinois Republican, and Allyson Y. Schwartz, a Democrat from Pennsylvania, have another. Florida Democrat Bill Nelson is the sponsor of Senate legislation.

“We have a solution, we have a way forward, we should tackle the issue,” Schwartz says. Bills were also introduced in earlier Congresses.

At the same time, other lawmakers are hoping for a wider discussion of the issues involved. Rep.Charles Boustany Jr., a cardiovascular surgeon who completed two residency programs, says he’s concerned about the projected shortage but isn’t convinced that adding slots will be helpful in every instance.

“What we really need to do is take a hard look at what the physician workforce appears to be right now and what are the factors that are creating shortages,” says the Louisiana Republican. “It’s a complex issue. I don’t know if the answer is to just simply throw more money at the problem, but to take a look at the factors affecting each specialty separately.”

A bipartisan group of seven senators signed a letter in the previous Congress asking the National Institute of Medicine to examine the graduate medical education program, as well as to recommend changes. The time for the study has been extended, says institute spokeswoman Jennifer A. Walsh, and a report with recommendations is expected next spring.

Proponents of lifting the Medicare cap say the issue demands more urgency than is evident on Capitol Hill.

“You can’t just flip a switch and crank out more doctors,” says Alex B. Valadka, a neurosurgeon and spokesman for the Alliance of Specialty Medicine. To become practicing physicians, students typically have to complete four years of medical school and at least three years of residency training, which often extends to six or seven years for specialty care, he says.

More importantly, says Grover of the AAMC, the crunch isn't that far off. Theoretically, there are enough residency slots for all U.S. medical school graduates right now, he says, with the remainder taken up by those who went to school abroad. In the next couple of years, however, the number of aspiring doctors in domestic medical schools will eclipse the number of first-year residency positions, Grover says.

The House Ways and Means Committee, which has jurisdiction over Medicare, is looking at the issue of graduate medical education, and lawmakers are interested, says a panel spokeswoman. But the committee is still in the early stages of discussion, and raising the caps would be difficult and require careful evaluation in today's touchy budget environment, the spokeswoman says.

Texas Republican Kevin Brady, chairman of the Ways and Means Health Subcommittee, called doctor training "an important part of the overall solution" in a written statement. Yet Brady suggested that his focus is on finding a way to permanently replace Medicare's physician reimbursement system. Some proponents of lifting the residency cap hope solving the payment issue might be a precursor to action on the training question or even a potential vehicle to move it along.

"This country faces a long-term physician shortage. But if we don't enact a permanent solution this year that reimburses Medicare doctors fairly, then America's seniors will face challenges finding doctors as well. That must be the top priority of Congress and the White House," Brady said.

Rep. Michael C. Burgess, the sponsor of legislation to overhaul the Medicare reimbursement formula, says he is focused on the doctor payment issue because it's the most immediate. But the Texas Republican, who is an obstetrician and gynecologist, says concerns about residency slots are also something Congress will need to tackle.

"The pull on the young college graduate to go to medical school is still there," says Burgess. "We've made the road hard for them, we've made the rewards diminished at the other end of that road for them, but we're very fortunate people are still driven by that fundamental altruism of wanting to go into medicine to help people. I hope we can do something before that flame extinguishes."

FOR FURTHER READING: *Proposed cuts in graduate medical education, 2012 CQ Weekly, p.354; medical resident workload, 2011 CQ Weekly, p. 2365; House passes bill to alter medical student funding, 2011 CQ Weekly, p. 1144; provisions of the Medicare prescription drug benefit law, 2004 CQ Weekly, p. 238; teaching hospitals lobby to block Medicare cuts, 1999 CQ Weekly, p. 1148; what the budget bill does, 1997 CQ Weekly, p. 3082.*