HOD ACTION: Council on Medical Education Report 15 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 15-A-10

Subject: Securing Funding for Graduate Medical Education

Presented by: Susan Rudd Bailey, MD, Chair

Referred to: Reference Committee C
(Floyd A. Buras, Jr., MD, Chair)

Council on Medical Education (CME) Report 3-I-09, "Securing Funding for Graduate Medical Education," broadly addressed issues of graduate medical education (GME) funding, provided an update on how the medical workforce is essential to health system reform, and provided examples of state, regional, and federal innovations. The report called for our American Medical Association (AMA) to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform [HSR]) and advocate for expanded and broad-based funding for GME from federal, state, and commercial entities, with a report back at the 2010 Annual Meeting. (See Policy H-310.917, AMA Policy Database.)

During recent months, the AMA has continued to closely track proposals and considerations related to physician workforce and HSR. The following is a summary of important recent congressional activity and AMA advocacy efforts.

CONGRESSIONAL ACTIVITY AND AMA ADVOCACY REGARDING GME

On December 14, 2009, twelve organizations including the AMA, representing the nation's physicians and medical education programs, requested support for Senate Amendment 2909 to the "Patient Protection and Affordable Care Act" (H.R. 3590), filed on December 4 by Senators Bill Nelson (D-FL), Harry Reid (D-NV), Charles Schumer (D-NY), John Kerry (D-MA), Debbie Stabenow (D-MI), and Patrick Leahy (D-VT). This amendment recommended increasing the number of Medicare-supported GME positions by 15,000 new training slots (see Appendix A – AMA letter to US Senate).

On December 16, the AMA e-mailed 13,000 US residency program directors and others in the GME community via its *GME e-Letter* to urge their support of Senate Amendment 2909 (see Appendix B – 12/16/09 *GME e-letter*).

On December 19, Senate Amendment 2909 was not included in the manager's amendment to the Senate HSR bill.

President Barack Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) into law on March 23, 2010. It is now Public Law 111-148. GME provisions in the law authorize redistribution of current unused GME residency slots to qualifying hospitals to address physician shortages in rural and other underserved areas, especially in primary care and general surgery. The law includes provisions that would provide more flexibility to GME programs to include training in outpatient settings in Centers for Medicare and Medicaid Services' (CMS) funding formulas, preserve GME positions from closed hospitals based on certain criteria, and offer development grants to teaching health centers to enable newly accredited or expanded primary care residency

programs meeting certain criteria (Sec. 5503-5506 and 5508). Public Law 111-148 also establishes a Health Workforce Commission (Sec. 5101) to provide recommendations to Congress and the Administration concerning national health workforce priorities, goals, and policies. Physician representation is very limited on the Commission.

The new HSR law takes some steps to strengthen primary care and general surgery training programs by increasing Medicare's fees for primary care and bringing Medicaid's primary care fees into line with Medicare's. Consistent with AMA policy, the law includes provisions to redistribute unused GME positions to qualifying hospitals to address physician shortages. The law reverses recent CMS funding rules and provides more flexibility for GME programs to count training in outpatient settings. The law also preserves GME positions from closed hospitals based on certain criteria. The law offers modest expansion in federal support of residency training, but it amounts to fewer than 300 new positions and is far below what the population growth and aging population will require. To adequately address physician shortages, legislation is still needed to lift the cap on Medicare-supported GME positions, especially in undersupplied specialties and underserved areas, as specified by AMA policy.

EXPANDED HEALTH CARE ACCESS UNDER HSR MAY CREATE MORE DEMAND FOR PHYSICIAN WORKFORCE

Between 2002 and 2006, three separate forecasting models (Council on Graduate Medical Education, Association of American Medical Colleges [AAMC], and Cooper et al.), showed that by 2020, the demand for physician services will exceed the supply by 85,000 to 200,000 physicians, especially in medically underserved regions and front-line specialties like primary care and general surgery. Since 2000, at least 22 states and 15 medical specialties have reported current physician workforce shortages. An additional five states and five medical specialties have predicted shortages in the very near future.[1]

Senate Amendment 2909 had broad backing in the Senate and was supported by several academic and professional medical organizations including the AMA, American Osteopathic Association, American College of Physicians (ACP), American College of Surgeons, American Academy of Pediatrics, Organization of Student Representatives, and the AAMC. However, the American Academy of Family Physicians (AAFP), researchers at Dartmouth University, and Fitzhugh Mullan, MD, Murdock Head Professor of Medicine and Health Policy, School of Public Health and Health Services, the George Washington University, opposed the amendment. They cited studies suggesting that geographic regions with more physicians have greater health-care costs with no accompanying improvements in outcomes or satisfaction and argued that the US does not face an overall shortage of physicians.[2] Those opposed recommend maintaining the cap on resident funding, shifting medical education resources to primary care, more strategic distribution of physicians (geographically and across the primary care-specialty spectrum), the expanded use of physician assistants and nurse practitioners in both the generalist and specialist sectors of the care delivery system, and reforming the reimbursement system to provide incentives for integrated and coordinated medical care.[3]

THE NEED FOR ADDITIONAL FUNDING TO INCREASE THE NUMBER OF MEDICAL RESIDENCY TRAINING SLOTS TO HELP ENSURE AN ADEQUATE WORKFORCE

Health care costs are continuing to grow faster than the economy; and employers, government, and individuals are straining under the financial burden. In 2005, 133 million Americans (50%) had at least one chronic condition; chronic diseases account for 70% of all deaths in the United States each year, and the medical care costs of people with chronic diseases account for more than 75% of the nation's $2.5 trillion medical care costs.[4, 5] In this environment, physicians are pressured to see

more patients in less time, are inundated with administrative paperwork and regulatory requirements, and have additional pressure to stay current with an overload of information in a rapidly changing medical environment that is increasingly more technical and complicated.[6] The number of active physicians approaching retirement age is increasing. A recent AAMC/AMA survey found that one third of active physicians over age 50 would retire today if they could afford to.[7]

Another pressing medical workforce issue is raised by a recent study showing that emergency departments are facing inadequate on-call coverage by specialist physicians.[8] Malpractice concerns, pressures on day-to-day practices, lifestyle constraints, and reimbursement issues are among the key reasons that specialists are reluctant to provide on-call emergency department care. Of all on-call specialists, the services of plastic and hand surgeons were most frequently reported as difficult to obtain.

The increase in the number of female physicians also has had a significant workforce impact. Today, women constitute 50% of medical students, 44% of residents, and 27% of the total US medical workforce, and are more likely than men to go into primary care. In 1985, women constituted 15% of the internists, pediatricians, and family physicians in the United States, but by 2005, they constituted 32% of these specialties. The responses of women in the AAMC/AMA study showed that women physicians may be more likely to work part-time and to migrate toward fields that offer a more controllable lifestyle than their male counterparts.[7]

THE IMPACT OF GROWTH IN NEW AND EXISTING MEDICAL SCHOOLS ON GME AND HEALTH CARE WORKFORCE SHORTAGES (FOCUSING ON SOME STATES, REGIONS, AND SPECIALTIES)

In response to future physician workforce needs, enrollments in medical school have been rising by about 2% per year over the past 5 years. Fifty percent of that increase has come from the creation of new medical schools and the rest from expansions of existing schools.[9] Meanwhile, GME positions have been growing by only about 1%.[10] There is little or no planning or rational connection between medical school enrollments and GME. Furthermore, much of the growth in GME is at the "back end" in subspecialty fellowships—and not at the "front-end" in core training programs.

Regardless of the impact of federal HSR, more states are focusing on medical workforce needs. An exhaustive review is beyond the scope of this report, and the AAMC Center for Workforce Studies has recently updated its publication, *Recent Studies and Reports on Physician Shortages in the U.S.*[1] However, a few examples to provide a glimpse of the range of state initiatives follow.

- Medical school growth is occurring in some states, such as Florida, that are not producing enough doctors for their population. However, growth in the number of medical students is not being matched by growth in residency training positions. For example, Florida has only 18 resident physicians per 100,000 population—about half the national average of 35 resident physicians per 100,000 population.[11]

- Improving financial access to medical care can also create an apparent physician shortage. For example, Massachusetts ranks first among the 50 states in the ratio of doctors to population. (See Appendix C – physician supply figure)[12] In addition, the state has four medical schools, and there are 80 resident physicians per 100,000 population, compared to the national average of 35.[11, 13] State health reforms have led to an increase in the number of insured patients and rising demand for physician services. The Massachusetts Medical Society's 2008 Physician Workforce Study found that 12 of 18 specialties evaluated were in short supply. Internal and

family medicine doctors were in critically short supply and experienced the highest degree of stress.[14]

- In many states, the geographic distribution of physicians is uneven. For example, although the physician-to-population ratio places Illinois 20th among the states, it is still below the national average of 254.5 physicians per 100,000 population.[12] Furthermore, the distribution of physicians in Illinois is highly uneven, with the highest proportion located north of Interstate 80 and near the state's larger urban areas.

- New Jersey has two medical schools and 31 resident physicians per 100,000 population.[11, 13] The state, however, anticipates a shortage of physicians by 2020 and has established a new Center for Medical and Health Workforce Planning to guide the allocation of resources based on its future workforce needs.[15]

- Idaho has no medical schools and only 3 resident physicians per 100,000 population.[11] Idaho, however, has established collaborative relationships with medical schools and GME programs in Washington and Utah to support its future physician workforce needs.

State initiatives notwithstanding, a study published by the AAFP's Robert Graham Center showed that even as some states have demonstrated a willingness to fund expansion of medical education (new medical schools and expanded enrollments), there is remarkably little direction or funding to purposefully tailor physician training in GME to the future needs of the population.[16]

THE IMPACT OF CONGRESSIONAL INACTION ON GRADUATES OF US MEDICAL SCHOOLS

Many institutions exceed their Medicare cap, but continue to fund growth in residency and fellowship training slots. Despite the cap, the number of resident physicians began increasing from 2002 through 2007, with a net increase of 8%.[10] However, this growth of resident physicians (financed by hospitals) was driven by a 7.6% increase in new entrants, mostly US citizen international medical graduates (IMGs), and increasing rates of subspecialization that require longer training and lead to fewer physicians entering generalist careers.[10]

Every residency training program has negotiated financial arrangements with its sponsoring institution (hospital, academic medical center, consortium, etc.). The general fiscal health of hospitals will probably determine whether this observed GME growth continues. In the long run, reimbursement reform may begin to reward accountable health care organizations (ACOs) that have the ability to manage complex chronic diseases efficiently and prevent unnecessary hospitalizations. It would make sense for residency training to expand in ACOs.

Unless Congress passes additional legislation to ease Medicare's limits on GME funding for physician training, the current legislation will add fewer than 3,000 additional physicians over the next decade, and the number of physicians per capita will actually decrease.[9] Given the long pipeline for physician training (7 years post college at a minimum), combined with the years required to build and accredit new residency training programs, expanding GME funding now will not have a major impact on the doctor-to-population ratios for several decades.

COMPETITION IS INCREASING FOR RESIDENCY SLOTS

A growing number of US citizen MD graduates (from both domestic and international medical schools) may be unable to obtain residency training in the United States. Graduating US medical students compete with immigrant physicians for a limited pool of entry-level GME positions. From 2001 to 2007, the number of IMGs entering GME in the United States increased by 891 (13.8%).[17]

Similar to 2009, following the 2010 National Resident Matching Program (NRMP) there were 1,060 unfilled positions in all specialties and an essentially equal number of unmatched graduates of US allopathic schools (US MDs) (1,078).[18] Most of the unfilled positions were preliminary GY1 positions in surgery (461), medicine (105), and transitional year (35). These stand-alone internships do not guarantee future training at GY2 levels or entry into complete core residency programs that would provide eligibility for board certification. Board certification is becoming increasingly important to be credentialed by a hospital or insurance plan.

Changes in the pattern of IMG choices of specialty were significant and almost the inverse of US graduates from 2002 to 2007. As a general rule, IMGs are taking positions that have fallen out of favor with US MDs and DOs, and IMGs are being displaced from the specialties that have gained popularity with US medical graduates. For example, there have been substantial increases of IMGs in primary care specialties and obstetrics/genecology, and major decreases of IMGs in anesthesiology, pathology, psychiatry, and physical medicine and rehabilitation. However, there were some specialties and subspecialties in which numbers of IMGs increased along with US MDs, including the subspecialties of internal medicine, pediatrics, emergency medicine, and general surgery.[19]

These trends have significant repercussions for the composition of the physician workforce. In response to the 2009 Match results, Steven E. Weinberger, MD, FACP, senior vice president for medical education and publishing, ACP, said, “We are witnessing a generational shift from medical careers that specialize in preventive care, diagnostic evaluation, and long-term treatment of complex and chronic diseases, to specialties and subspecialties that provide specific procedures or a very limited focus of care.”[20]

VARIABILITY IN THE QUALITY OF MEDICAL EDUCATION

Recent studies show US medical education is further stressed by the growing number of medical students from offshore Caribbean schools needing clinical clerkships and seeking residency training slots. Each year, approximately 2,500 US citizens enter medical school outside the United States, located mostly in the Caribbean.[21] Eighteen new Caribbean schools have opened since 2000. Funding comes primarily through tuition, and students who attend these medical schools qualify for US federal student loans. Although efforts to accredit Caribbean schools have begun, these efforts are nascent.

Caribbean medical schools do not have teaching hospitals. These medical schools pay hospitals in the United States for students’ clinical training.[21] In addition, graduates of Caribbean medical schools compete with US medical students for GME positions. Annually, 1,500 US IMGs return to the United States to enter GME.[17] The 2009 NRMP results show that between 2008 and 2009, active applicants who are US citizen IMGs showed the largest increase among all the applicant groups in both numbers (421) and percent (14.2%).[19] In 2010, the number of active US citizen IMG applicants continued to increase, but at a slightly lower rate (8.9%).[18]

Aside from quantity, many concerns about the quality of training provided to these graduates are being raised. Van Zanten and Boulet studied the performance of physicians who attended medical schools in the Caribbean and found considerable variation in quality indicators and first-attempt pass rates on the United States Medical Licensing Examinations.[22,23] Furthermore, their entry into residency may be enhanced by factors other than basic science or clinical knowledge, such as the ability to speak English, clinical training at a US institution, and lack of visa requirements.[24] Approximately 20% of Caribbean medical school graduates are not accepted into US residency programs. Many are highly indebted with the US Department of Education.[21]

RECENT INTERNAL REVENUE SERVICE DECISION

After years of litigation, on March 2, 2010 the Internal Revenue Service (IRS) announced (IR 2010-25) that it would return Federal Insurance Contributions Act (FICA) taxes to residents and teaching hospitals who filed claims before April 1, 2005. The exemption recognizes the status of medical residents as students for FICA tax purposes.[25]

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education envisions a health care system based on an adequate number of highly trained physicians who can work efficiently to provide high-quality care to all US citizens. At its November 2009 Meeting, the Council on Medical Education recommended that the AMA work with the Association of American Medical Colleges to develop a joint statement to advocate for the expansion of the graduate medical education (GME) workforce. This position is consistent with AMA policy, and both organizations have advocated for increased funding for GME.

Therefore, the Council on Medical Education recommends that the following be adopted and the remainder of this report be filed:

1. That our American Medical Association reaffirm:

    - Policies H-200.955 and H-305.929, which increases Medicare-supported GME positions for primary care, general surgery, and other undersupplied specialties and in underserved geographic areas to address physician shortages and to ensure access to care;

    - Policy H-200.955, which maintains availability of currently vacant GME positions and support redistribution based on need;

    - Policy H-305.929, which maintains adequate and stable Medicare and Medicaid GME funding levels;

    - Policy H-305.929, which investigates additional sources of GME funding (e.g., private payers); and

    - Policy H-160.919, which encourages interprofessional training, practice-based learning, and information technology to prepare the current and future health workforce.

2. That our AMA actively advocate for strong physician representation and significant participation in any proposed health-care workforce advisory committees, demonstration projects, or workforce assessments, since PL 111-148 calls for a “Health Workforce Commission.” (Directive to Take Action)

3. That our AMA continue to advocate for adequate and sustained federal funding of pediatric residency programs independent of Medicare payments. (Directive to Take Action)

4. That Policy H-310.917 be amended by deletion of "with a report back to the House of Delegates."

Fiscal Note: Less than $5,000 of staff time.

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APPENDIX A

December 14, 2009

United States Senate
Washington, DC 20510

The undersigned organizations, representing the nation's physicians and medical education programs, request your support for Senate Amendment 2909 offered to the "Patient Protection and Affordable Care Act" (H.R. 3590). This important amendment would increase the number of graduate medical education positions by 15 percent.

As a result of provisions included in the Balanced Budget Act of 1997, our nation's physician training capacity has been static since 1997. The BBA established limitations on the number of residency training positions, with little opportunity for increasing capacity. There is now mounting evidence that our nation faces a significant shortage of physicians in primary care, general surgery, as well as many specialties.

Our population is both increasing and aging. The U.S. Census Bureau projects that the population will exceed 350 million people by 2025 and the number of Medicare beneficiaries will almost double during this same time period. Additionally, the nation's physician workforce resembles the broader society. Presently, more than one-third of all practicing physicians are over the age of 55, meaning that they are likely to retire in the next two decades. These events will exacerbate the current acknowledged physician shortage.

The Senate is striving to approve legislation that would expand health care coverage to millions of individuals presently uninsured and improve the quality of coverage for millions more. Unfortunately, coverage does not equal access. We must educate and train a cadre of physicians capable of meeting the health care needs of our growing and aging population, with priority given to those specialties and subspecialties--including primary care and general surgery-- that are facing shortages and are most needed.

Senate Amendment 2909 is a necessary step towards ensuring the future physician workforce. We urge you to signify your support by becoming a cosponsor and by supporting the amendment when considered by the Senate.

Alliance for Academic Internal Medicine
American Academy of Ophthalmology
American Association of Colleges of Osteopathic Medicine
American Association of Physicians of Indian Origin
American College of Physicians
American College of Surgeons
American Medical Association
American Osteopathic Association
American Society of Cataract and Refractive Surgery
Association of American Medical Colleges
Association of Program Directors in Internal Medicine
Medical Group Management Association

APPENDIX B

Graduate Medical Education (GME) e-Letter

Special Edition, December 2009

Dear colleagues,

We need your **immediate** help **today** in contacting your U.S. Senators to urge them to support **Senate Amendment 2909** (SA 2909) to the Senate health system reform bill, the "Patient Protection and Affordable Care Act" (H.R. 3590). SA 2909 would add up to 15,000 new GME training slots. It is sponsored by a group of Democratic Senators including the Majority Leader Harry Reid (D-NV), Assistant Majority Leader Dick Durbin (D-IL), and Vice Chair of the Democratic Caucus Chuck Schumer (D-NY).

Since 1997, when Congress froze ("capped") Medicare's support for GME training, the AMA along with other key stakeholders has worked hard to ease those restrictions. This is the closest we have been in a dozen years to actually doing so. SA 2909 would address the projected physician shortage and ensure access to care by increasing the number of GME positions.

This effort is strongly supported by the American Medical Association, the American College of Physicians, the American College of Surgeons, the American Osteopathic Association, the Association of American Medical Colleges and several other national organizations--see the Dec. 14 letter to the U.S. Senate. (PDF)

SA 2909 is a necessary step towards ensuring the future physician workforce. Please call your U.S. Senators today by contacting the Capitol Hill Switchboard at (202) 224-3121; they will forward you to the appropriate Senate offices.

Paul H. Rockey, MD, MPH, Director
AMA Division of Graduate Medical Education

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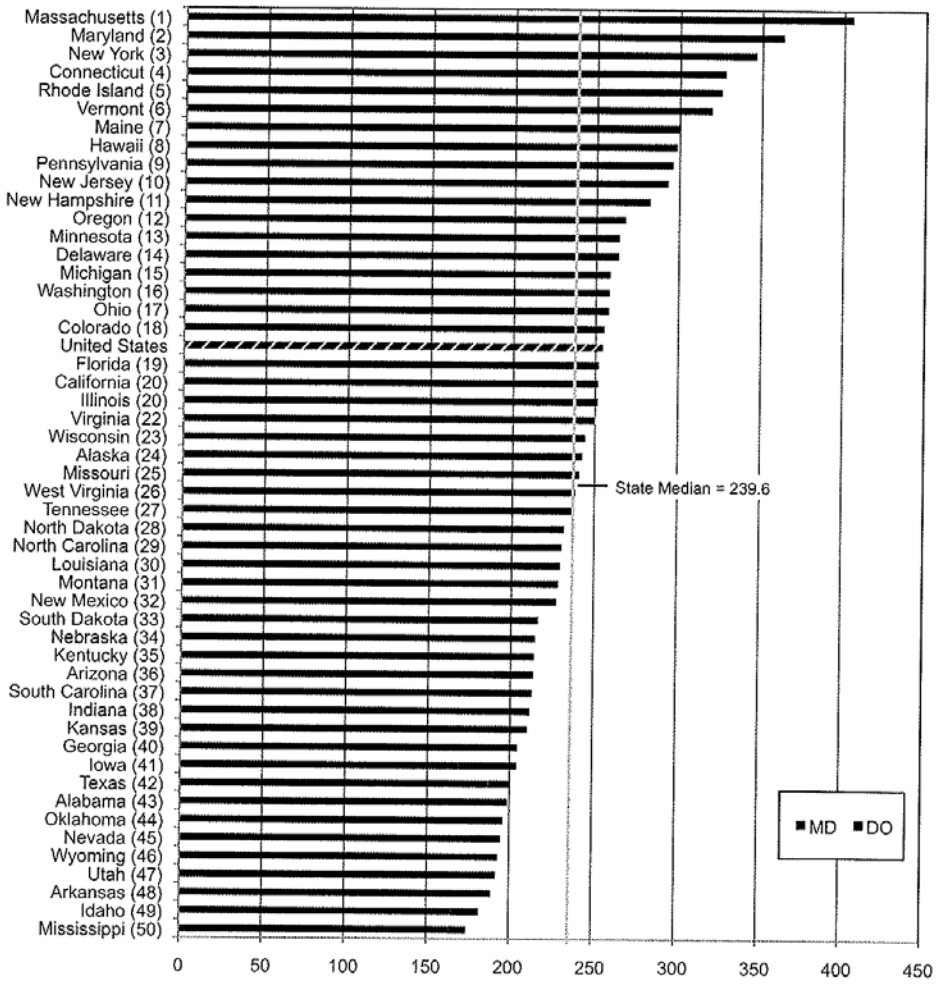
APPENDIX C

AAMC

Figure 1. Active Physicians per 100,000 Population by Degree Type, 2008



Sources: July 1, 2008 population estimates are from the U.S. Census Bureau (Release date: December 22, 2008). Physician data are from the 2009 AMA Physician Masterfile (December 31, 2008).