30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?

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by the

Association of American Medical Colleges

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The Association of American Medical Colleges (AAMC) is pleased to submit this statement to the record for the January 29, 2013, hearing, “30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care?” of the Health, Education, Labor, and Pensions (HELP) Subcommittee on Primary Health and Aging.

AAMC is a not-for-profit association representing all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians.

The AAMC applauds Subcommittee Chair Bernard Sanders, and Senators Mike Enzi and Rand Paul for convening this hearing on a timely and important topic. Five years ago – nearly to the day – the AAMC testified before the Committee on this matter at a hearing chaired by Senator Sanders, “Addressing Healthcare Workforce Issues for the Future.”

Much has changed in the five years that have passed. Enactment of the Affordable Care Act (ACA, P.L. 111-148 and P.L. 111-152) ushered historic reforms that will provide affordable health care coverage to as many as 32 million more Americans; many of these people finally will be able to access regular care for previously untreated health conditions. The first Baby Boomers entered the Medicare program in 2011, and for the next two decades, another 10,000 Americans will turn 65 daily. The nation’s medical schools already have taken the first critical step to address increased demand for physician services expected as the number of Medicare beneficiaries soars and coverage expands under the ACA: 15 new medical schools and 9 new osteopathic medical schools have opened since 2008, with several more planned. In combination with existing medical schools that have expanded enrollment, the number of medical graduates is currently on track to meet by 2016 the goal of a 30 percent increase in enrollment over 2002 levels.

Yet, despite this growing shift in demographics and the response of the medical education community, the central challenge discussed at the 2008 HELP Committee hearing remains a challenge today: the nation faces a critical shortage of physicians. By 2020, the shortfall will reach 91,500 physicians, and grow to more than 130,000 by 2025. While medical schools have taken action by graduating 30 percent more students, we have not seen a proportionate increase in the number of residency training or graduate medical education (GME) positions. The limited availability of residency positions – the direct result of a cap Congress imposed in 1997, freezing Medicare support for GME at 1996 levels – soon will preclude medical graduates from completing the supervised training required for independent practice. In other words, the best efforts of medical schools to increase the number of matriculates will not curtail the physician shortages unless Congress releases the bottleneck and lifts the federal cap on residency training support.

Underserved populations in both urban and rural areas will continue to bear the greatest burden of workforce deficits, but extensive shortages across a number of specialties are likely to impede access to care for many Americans. The AAMC projects there will be 45,000 too few primary care physicians by the end of the decade, hindering access to preventive care for millions.
Accordingly, in a 2010 survey of medical school deans, 75 percent (94 of 125 respondents) reported instituting or considering initiatives to encourage primary care.

Less commonly reported, but equally troubling, is the parallel shortage of more than 46,000 specialists, leaving patients with cancer, Alzheimer’s disease and dementia, hip fractures, and other ailments without immediate access to necessary care. These trends are of particular concern as the nation ages and requires specialty care for many age-related illnesses and disabilities.

Some have argued that policymakers should limit the number of specialists, based on a study suggesting that places with more generalists report lower Medicare spending and higher quality. These findings repeatedly have been challenged and invalidated – most recently in a January 2013 Working Paper for the Federal Reserve Board of Governors’ Finance and Economics Discussion Series – for neglecting to adjust appropriately for socioeconomic factors. The recent analysis clearly demonstrates that including the rate of uninsured and black in the regression negates the original conclusion correlating workforce composition with health care spending.

Indeed, prioritizing only one component of the workforce will be a futile strategy, as the broad scope of the problem necessitates an equally multi-faceted response. As the Subcommittee discusses potential solutions, the AAMC provides the following background principles about graduate medical education and teaching hospitals, and offers policy recommendations to consider in the interest of improving access to care for all patients.

**Background Principles**

**Medicare Supports GME to Ensure Access to Physicians and to Highly Specialized Services for Medicare Beneficiaries**

Physician training is inextricable from patient care, and Medicare historically has paid for its share of the costs of training and the highly sophisticated health services provided by teaching hospitals. Medicare reimburses teaching hospitals for a portion of these costs through two types of payments: Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments.

DGME payments are intended to offset the direct costs of GME, such as resident stipends and benefits; supervising faculty salaries and benefits; and allocated institutional overhead costs. These payments are tied directly to a program’s “Medicare share,” an institution-specific amount that reflects Medicare volume as a percent of patient care days at the institution. According to FY 2009 Medicare cost reports (www.HealthData.gov), Medicare DGME payments reimbursed less than one quarter of the total direct costs teaching hospitals incurred in 2009. The training costs above Medicare’s share are borne primarily by the program itself.

Medicare DGME payments are not limited to teaching hospitals; currently, community health centers and other teaching settings are eligible for DGME payments that, like teaching hospitals, are calculated based on the facility’s Medicare share. Congress repeatedly has clarified that Medicare GME support should remain tied to the level of Medicare services provided, rather
than diverting limited Medicare funds to providers that do not treat a substantial number of Medicare beneficiaries.

Medicare IME payments, on the other hand, are patient care payments that recognize the additional costs incurred by teaching hospitals because they maintain specialized services and treat the most complex, acutely ill patients. As stated in House and Senate report language when Congress created the IME adjustment as part of Medicare’s Prospective Payment System (PPS) in 1983,

This adjustment is provided in light of doubts … about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents … The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (House Ways & Means Committee Rept. No. 98-25, March 4, 1983, and Senate Finance Committee Rept. No. 98-23, March 11, 1983)

For example, AAMC member teaching hospitals operate 80 percent of Level 1 Trauma centers and provide a range of highly sophisticated services not offered elsewhere in communities. IME payments are meant to partially offset these costs. Providers that do not incur the unique patient care costs associated with caring for highly complex, severely ill inpatients (i.e., ambulatory sites that largely provide primary, non-acute care) do not qualify for these payments.

The specialized services supported in part by IME payments extend far beyond the locale of the recipient institution. Rather, in many cases, major teaching hospitals provide life-saving care to the entire region. Consider, for example, inpatient discharges for the University of Colorado Health Systems. As depicted in the map below, patients across the state of Wyoming, regions of Montana, New Mexico, and several other states beyond Colorado rely on services offered by the University of Colorado Health Systems.
Major Teaching Hospitals Offer A Comprehensive Range of Unique Services to All Patients

As described above, AAMC member teaching hospitals maintain the vast majority of the country’s critical standby units. In addition to the trauma centers, AAMC members operate: 79 percent of all burn care units; 40 percent of neonatal- and 61 percent of pediatric-ICUs; nearly half of surgical transplant services; over one-fifth of all cardiac surgery services; and 44 percent of Alzheimer centers. These institutions provide over one-third of all hospital charity care. Compared with physician offices and other hospitals, major teaching hospitals care for patients that are sicker, poorer, and more likely to be disabled or non-white.

At nearly half of academic medical centers, the majority of Medicare visits are provided in hospital-based clinics. Hospital Outpatient Departments (HOPDs) serve as a safety net for vulnerable populations, offering both primary care, and comprehensive and coordinated care settings for patients with chronic or complex conditions. Examples include access to pain centers, cancer clinics, or psychiatric care, as well as wrap-around services, such as translation and community-based services.

Academic medical centers also serve as vital partners to community-based facilities. A 2010 study described the barriers that community health centers (CHCs), which primarily provide primary care services, face in securing specialty care for patients; 91 percent reported difficulties in finding off-site specialists for uninsured patients, 71 percent for Medicaid patients, and 49 percent for Medicare patients, though hospital affiliations eased the difficulty in some cases. These findings suggest a major obstacle in ensuring timely treatment, as an October 2007 study in Health Affairs reported that 25 percent of visits to CHCs result in “medically necessary referrals for services not provided by the center.” The Health Affairs study describes that those CHCs affiliated with medical schools or hospitals report better access to specialty services, and notes, “If policymakers plan to extend access to primary care for the uninsured by increasing the number of CHCs, they must also address the problem of access to secondary and tertiary levels of care.” With major teaching hospitals treating a substantial and growing percentage of Medicaid and/or financially disadvantaged patients, the studies reinforce the importance of a comprehensive approach to resolving access issues, rather than growing the capabilities of one type of facility or specialty at the expense of others.

Teaching Hospitals Are Leading Innovative Efforts to Improve Care Quality and Efficiency

The current caps on physician training were imposed at a time when most researchers predicted that the delivery system would change rapidly and drastically under the influence of tightly managed care. Today, the health care delivery system is in a time of significant transformation with numerous federal, state, and private efforts under way to improve coordination and quality of care, increase access, and reduce cost – which may have a significant impact on demand for physician services.

Major teaching hospitals are at the forefront of many of these innovations in care delivery. AAMC member institutions account for less than 6 percent of all hospitals but constitute a much larger percentage of participants in reforms sponsored by the Centers for Medicare and Medicaid Services (CMS). For example, AAMC members make up 44 percent of Health Care Innovation Award grantees; 34 percent of the Innovation Advisors Program; 18 percent of all CMS
Accountable Care Organizations (ACOs); 38 percent of Pioneer ACOs; and 17 percent of Medicare Shared Savings Program participants.

Similarly, AAMC medical schools and teaching hospitals are innovating to prepare the next generation of health professionals for practice in a new delivery system. For example, AAMC has partnered with other health education associations through the Interprofessional Education Collaborative (IPEC) to focus on better integrating and coordinating the education of physicians, nurses, pharmacists, dentists, public health professionals, and other members of the patient health care team to provide more collaborative and team-based care.

It is too early to know the short- or long-term effect these nascent efforts will have on our future workforce needs, but these changes will take years to come to fruition. In the interim, it would be irresponsible to ignore the nation’s expanding health care needs. As demonstrated in Massachusetts, expanding insurance coverage leads to an initial increase in utilization of both primary and subspecialty care.

**Influencing Specialty Choice: Studies Indicate Debt Plays a Minor Role**

Many claim prohibitive debt levels lead medical students to choose careers other than primary care, but surprisingly little evidence supports this assertion. In fact, a thorough review of the academic literature shows little to no connection between debt and specialty choice. Rather, studies show specialty choice is a complex and personal decision involving many factors. According to AAMC’s annual survey of graduating medical students, the most important factors are a student’s personal interest in a specialty’s content and/or level of patient care; desire for the “controllable lifestyle” offered by some specialties; and the influence of a role model in a specialty. Student debt consistently ranks toward the bottom of the list for this question every year.

Further, federal programs, such as the National Health Service Corps (NHSC), offer incentives to help physicians manage their debt. A January 2013 study in *Academic Medicine* found that “physicians in all specialties, including primary care, can repay the current median level of education debt. At the most extreme borrowing levels … options exist to mitigate the economic impact of education debt repayment. These options include an extended repayment term or federal loan forgiveness/repayment program, such as IBR, PSLF, and the NHSC.”

In addition to the NHSC, other programs at the Health Resources and Services Administration (HRSA) have proven successful in guiding students toward a career in primary care and underserved communities. The Title VII health professions programs offer support for educational opportunities in these settings. Marking their 50th anniversary in 2013, these programs serve as a catalyst for innovations in education and training, helping the workforce over the years adapt to the nation’s changing workforce needs. Similarly, the Children’s Hospitals Graduate Medical Education program provides critical support to strengthen the future primary and specialty care workforce for the nation’s children.

The Teaching Health Center (THC) program is a new HRSA initiative, established in the Affordable Care Act and funded with a mandatory appropriation. The THC program provides
payments of $150,000 per resident, per year, to community-based, ambulatory patient care centers that operate primary care residency programs. These payments are being made at a far higher level than Medicare supports teaching hospitals. AAMC continues to support HRSA funding for this new program, given that the agency oversees the federal health center program, health professions workforce development programs, and other community-based entities. We look forward to studying the outcomes of the initial cohort of THCs, and how continued HRSA funding can sustain the higher payments made to these facilities.

It should also be noted that past attempts to influence specialty selection through Medicare GME payments have failed, leading the Medicare Payment Advisory Commission (MedPAC) to promote other mechanisms, such as clinical reimbursement, NHSC, and Title VII programs, instead. Since the mid-1990s, hospitals have received twice the DGME payment for primary care and geriatrics residents as compared to subspecialty fellowships, yet shortages persist. As observed by MedPAC in its November 2003 report on the Impact of Resident Caps on the Supply of Geriatricians, “[f]actors other than Medicare’s resident caps may better explain the slow growth in the number of geriatric physicians.” The report further notes that “federal policies intended to affect the number, mix, and distribution of the health care workforce should be implemented through specific targeted programs rather than through Medicare.”

Policy Recommendations

Despite the best-implemented health care delivery reforms, the growing and aging nation will need a larger physician workforce. The U.S. cannot afford to wait until the physician shortage takes full effect, as the education and training of each physician takes more than a decade. These recommendations are intended to clarify that an adequate supply of physicians must be achieved both through more efficient health care delivery models and by increasing physician training positions. No single approach is sufficient; all of the following are necessary to ensure an adequate supply of physicians:

1. The number of federally supported GME training positions should be increased by at least 4,000 new positions a year to meet the needs of a growing, aging population and to accommodate the additional graduates from accredited medical schools. The medical education community will be accountable and transparent throughout the expansion.

Training an additional 4,000 physicians a year would allow the nation to increase its expected supply of doctors by approximately 30,000 by the end of the decade – meeting approximately one-third of the expected shortage. This represents an expansion of approximately 15 percent over current training levels, which would provide a sufficient number of positions to accommodate U.S.-educated doctors while allowing for international medical graduates (IMGs) to occupy about 10 percent of training positions. Absent the necessary increases in residency positions, per capita numbers of physicians will continue to fall as the population grows and ages with rising per capita needs.

The AAMC believes that primary care is the foundation of a high-performing health system, but it is equally important to increase the supply of subspecialists in many areas. As patients age, incidence of both chronic and acute conditions rises dramatically; U.S. health care has made
great advances in the care of these conditions. Cancer, arthritis, diabetes, and other illnesses of adults will continue to be treatable disorders that require the care of oncologists, surgeons, endocrinologists, and other specialties. Children who previously would have succumbed to their illnesses will survive into adulthood but require decades of follow-up by primary care, pediatric subspecialists, and adult subspecialists. Meeting these needs cannot be accomplished without increasing the number of residency positions.

2. Current and future targeting of funding for new residency positions should be planned with clear attention to population growth, regional and state-specific needs, and evolving changes in delivery systems. Today, approximately half (2,000) of these additional positions should be targeted to primary care and generalist disciplines; the remainder should be distributed across the dozens of the approximately 140 other specialties that an aging nation relies upon. Attempts to increase physicians in targeted specialties by reducing training of other specialists will impede access to care.

Approximately half (or 13,000) of first-year residency training positions are in family medicine, internal medicine, and pediatrics; while many of these residents will go on to subspecialize, the number of fellowship (or subspecialty) training positions accounts for approximately 20 percent of all available GME slots. Even the largest internal medicine subspecialty, cardiology, trains fewer than 1,000 physicians a year; fewer than 500 oncologists are trained annually. Attempting to force physicians to forgo subspecialty training by limiting fellowship opportunities would have limited effect and, even if successful, would jeopardize timely access to care for patients who require a subspecialist.

Wait times for access to subspecialists continue to grow, necessitating that, in some cases, training capacity must be increased, combined with efforts to more efficiently use subspecialty care. The AAMC believes that the ideal team-based health care delivery and utilization model should efficiently use human resources to improve patient access to appropriate services. For example, some patients managed by specialists can be directed back to primary care providers with management plans for chronic conditions. Other providers in a variety of settings could care for lower acuity patients now treated by physicians. Optimizing utilization will help relieve both the burden on patients seeking to access appropriate health care services and on overwhelmed providers, but will not obviate the need to train more doctors.

Physician shortages will persist even if the Medicare funding caps are lifted today, given the severity of the problem and a likely modest rate of change in the delivery and payment systems. Increasingly, patient access to both primary and specialty care will be a challenge. As health care is better integrated – team care expands and unnecessary variations are reduced – newly insured patients will present in the offices of primary care providers. For many of those patients, primary care providers will need to coordinate the care of subspecialists for complex illnesses. These needs will outstrip the supply of many subspecialties at current levels, even if utilization rates are significantly reduced.

It is unclear how extensive this increase in utilization will be over the course of subsequent years. Therefore, it is imperative to target the current and future increase in federally funded residency positions through ongoing analysis of health care utilization and estimates of future
demand, rather than by prescribing a static specialty composition that does not actively respond to a dynamic health care environment.

3. In addition to expanding support for GME, policymakers should leverage clinical reimbursement and other mechanisms to affect geographic distribution of physicians and influence specialty composition.

While the ACA took steps to increase reimbursement to primary care providers, policymakers will need to reimburse cognitive and patient management services in a way that makes these specialties more attractive to new physicians. Similarly, programs like NHSC and Title VII have successfully improved distribution of primary care providers to underserved areas, but policymakers must find ways to reward physicians economically who serve geographically or economically underserved communities. Education and training cannot overcome the intense market incentives that influence physician choices.

Recent studies show 31 percent of physicians are not accepting new Medicaid patients. Teaching hospitals and physician faculty are more likely to serve poor and vulnerable populations and will be asked to see more patients for whom reimbursement is less than the cost of providing care. Physicians and other providers must be paid adequately to ensure that patients have access to care.

4. The federal government should continue to invest in delivery system research and evidence-based innovations in health care delivery.

Lifting the 15-year freeze in federal support for physician training by 15 percent only would meet one-third of the expected shortage of physicians by the end of this decade, and is insufficient to ensure access to care. Delivery system innovations that improve efficiency, integrate care, and leverage other health professionals also will be necessary.

The ACA created new opportunities for health care delivery reform at the federal level and for the states, which are now in the beginning stages of implementation. AAMC institutions and faculty are working with the federal government to improve delivery and payment by participating in numerous initiatives. AAMC members are focused on the transformation of health care delivery, including through the Patient-Centered Outcomes Research Institute (PCORI).

AAMC teaching hospital members receive significant public funding for their missions and are willing to be meaningfully accountable for that support. The training of physicians and other health professionals has changed significantly in the last 15 years and is increasingly focused on teaching doctors to improve systems of care. As measures are created, tested, and evaluated, these data will demonstrate the increasing ability of new physicians to work in teams; facilitate system changes to improve population health; and foster continuous quality improvement.

Continued research will inform how providers, systems, and payers can ensure access to care as well as optimal outcomes. Along with the AAMC, the federal government should continually
assess how these delivery changes affect workforce needs and make the necessary additional investments in training to provide an adequate physician workforce.

Communities in all regions of the country rely on academic medical centers for high-quality medical care, advanced research, job creation, new business development, and education of medical professionals. As the nation faces an unprecedented demand for health care services, continued support for medical schools and teaching hospitals will be essential.

Thank you again for the opportunity to submit this statement for the record and for your leadership in addressing this important subject. The AAMC looks forward to working with the Subcommittee in strengthening access to health care for patients across the country.