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Reforming Medicare-Financed Graduate Medical Education

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REFORMING MEDICARE-FINANCED GRADUATE MEDICAL EDUCATION

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In 1965 Congress voted to subsidize American medical education through the Medicare program because it believed that educating medical professionals was in the best interest of the public.[1] Today, Medicare is the single largest payer of graduate medical education (GME), the training that physicians receive between medical school and independent practice, in the United States.[2] In 2009 alone, Medicare GME payments covered the costs of 90,000 residents in more than 1,100 accredited teaching hospitals across the United States.[3]

Despite receiving over $9.5 billion in subsidies for GME from the federal government in 2009,[4] teaching hospitals are losing money and are not producing enough primary care physicians to meet the medical demands of society.[5] The reasons for this are threefold. First, teaching hospitals inherently have higher operating costs than nonteaching hospitals because of their dual purpose to educate physicians and to treat patients.[6] Second, in America's capitalist marketplace, public goods like teaching hospitals must compete with private, nonteaching hospitals for market share. Finally, due to the rising costs of medical education, doctors tend to specialize in fields

1. 42 U.S.C. § 1395 (d)(5)(B)(2006); H.R. REP. NO. 89-213 (1965); *see also* Eugene C. Rich et al., *Medicare Financing of Graduate Medical Education: Intractable Problems, Elusive Solutions,* 17 J. GEN. INTERNAL MED. 283 (Apr. 2002).

2. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: ALIGNING INCENTIVES IN MEDICARE 103 (June 2010), *available at* http://www.medpac.gov/documents/jun10_entirereport.pdf. [hereinafter MEDPAC REPORT 2010].

3. Ian S. Metzler, Karen Ganjawalla, Krista L. Kaups, & John G Meara, *The Critical State of Graduate Medical Education Funding*, AM. C. OF SURGEONS (Nov. 8, 2012); *see also* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: ALIGNING INCENTIVES IN MEDICARE 3 (June 2009), *available at* http://www.medpac.gov/documents/jun09_entirereport.pdf [hereinafter MEDPAC REPORT 2009].

4. Catherine Dower, *Health Policy Brief: Graduate Med. Educ.*, HEALTH AFFAIRS 1 (Aug. 16, 2012), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=75.

5. Avik Roy, *MedPAC: 64% of Hospitals Lose Money on Medicare Patients*, FORBES (Sept. 21, 2011, 3:04 PM), http://www.forbes.com/sites/aroy/2011/09/21/medpac-64-of-hospitals-lose-money-on-medicare-patients/.

6. *See generally* MOLLY COOKE, DAVID M. IRBY, & BRIDGET C. O'BRIEN, EDUCATING PHYSICIANS: A CALL FOR REFORM OF MEDICAL SCHOOL AND RESIDENCY 165 (2010).

with higher reimbursements rates, such as surgery or anesthesiology, and leave hospitals with a shortage of primary care physicians.[7]

This Note attempts to resolve the GME funding debate. Part I discusses the purpose of GME and traces its historic ties with Medicare. Part II outlines GME's current uses and identifies gaps in the health care delivery system. Part III concedes that the Affordable Care Act's provisions on medical education were a step in the right direction, but argues that further reforms are imperative if GME and its financing sources are to produce an adequate and well-distributed supply of physicians. Part IV evaluates the effectiveness of leading reform arguments. Finally, Part V warns against cutting GME payments to hospitals and instead advocates for reforming current GME payment schedules and removing the current cap on the number of residents who qualify for Medicare subsidies.

PART I: A NEW RELATIONSHIP: GME FUNDING AND MEDICARE

When Congress created Medicare in 1965, it believed that medical training was a public good, which was key to the survival of the American health care system.[8] "[E]ducational activities enhance the quality of care in an institution, and it is intended . . . that part of the net cost of such activities should be borne to an appropriate extent by the hospital insurance program."[9] Accordingly, Congress allocated taxpayer dollars to GME and created a complex reimbursement schedule to ensure GME payments were dispensed properly.[10]

A. Direct Medical Education Payment

Medicare GME payments are divided into two prongs, direct graduate medical education (DGME) and indirect medical education (IME) payments.[11] DGME payments include stipends and fringe benefits for residents, salaries and fringe benefits for faculty who supervise the residents, and miscellaneous institutional overhead costs.[12]

Today, most DGME payments are based on a standard formula of an accredited teaching hospital's total per resident costs[13] (in base year 1984)

7. Katherine Hobson, *Doctors Vanish from View*, U.S. NEWS & WORLD REP. (Jan. 23, 2005), *available at* http://www.merritthawkins.com/pdf/USNewsArticle_TheDoctorIsOut.pdf (last visited Aug. 15, 2014).
8. H.R. REP. NO. 89-213, at 32 (1965); S.REP. NO. 89-404, at 1 (1965).
9. H.R. REP. NO. 89-213, at 32 (1965); *see also* Rich, *supra* note 1.
10. H.R. REP. NO. 89-213, at 32 (1965); S. REP. NO. 89-404, at 1 (1965).
11. GME: 42 C.F.R. §§ 413.75-413.88 (2006); IME: 42 C.F.R. § 412.105 (2006).
12. *Id*. at §§ 413.75-413.88.
13. 42 C.F.R. §§ 413.77 (2006).

updated for inflation.[14] As part of the Balanced Budget Act of 1997, the number of resident slots nationwide that qualify for GME reimbursement were capped at their 1996 levels.[15] Congress believed that the increase in residents was leading to an oversupply of physicians.[16]

Under Medicare's current reimbursement plan, residents who specialize receive higher reimbursements than their non-specialized counterparts.[17] For example, residents training in primary care (family practice, general internal medicine, general pediatrics, obstetrics,[18] and gynecology) and certain selected specialties (geriatrics, public health, preventative medicine)[19] earn considerably less in lifetime earnings than specialists.[20] Although this reimbursement schedule was created to mitigate the increased teaching costs associated with training specialists,[21] an unanticipated and problematic side effect is that the payment schedule incentivizes teaching hospitals to train specialists. [22]

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14. 42 C.F.R. §§ 413.77(d)(2)(i) (2006).

15. P. Hannah Davis, *The Effects of the Balanced Budget Act of 1997 on Graduate Medical Education: A COGME Review*, COUNCIL ON GRADUATE MED. EDUC., U.S. DEP'T OF HEALTH & HUM. SERVS., 2 (Mar. 2000), http://www.hrsa.gov/advisory committees/bhpradvisory/cogme/Publications/budgetact.pdf.

16. Brian Rye, *Assessing the Impact of Potential Cuts in Medicare Doctor-Training Subsidies*, BLOOMBERG GOVT. BRIEF, at 10 (Feb. 28, 2012) (responding to predictions that resident-training activities would cause a surplus of physicians, "the Balanced Budget Act of 1997 contained several provisions to stem the growth of resident positions," including caps on "Medicare-funded resident slots at . . . 1996 levels.").

17. *Medicare Direct Graduate Medical Education (DGME) Payments*, ASS'N AM. MED. CS., https://www.aamc.org/advocacy/gme/71152/gme_gme0001.html [hereinafter *Medicare DGME Payments*] (last visited Apr. 1, 2014).

18. Obstetrics is the branch of medicine that deals with the care of women during pregnancy, childbirth and the recuperative period following delivery.

19. Geriatric care is the medical care of older or elderly people. Public health is treatment at the level of population health (such as administering city wide inoculations and infectious disease specialists) rather than individual health, Preventative medicine includes those measures taken to prevent diseases or injuries rather than measures aimed at curing diseases or treating symptoms.

20. Dower, *supra* note 4, at 3.

21. COOKE, *supra* note 6, at 172; Fitzhugh Mullan et al., *The Geography of Graduate Medical Education: Imbalances Signal Need for New Distribution Policies,* 32 HEALTH AFFAIRS 1914, 1915 (2013), http://content.healthaffairs.org/content/32/11/1914.full

22. Nicholas A. Weida, Robert L. Phillips, & Andrew W. Bazemore, *Does Graduate Medical Education Also Follow Green?*, 170 ARCHIVES INTERNAL MED. 389, 389-90 (2010).

B. Indirect Medical Education Payments

IME payments are a second prong of GME payments. In 2009, Medicare IME payments totaled $6.5 billion.[23] IME payments are intended to cover the additional costs of running an accredited teaching program.[24] These additional costs include lower resident productivity as compared to seasoned physicians, as well as the additional diagnostic testing residents order as part of their learning experience.[25] IME costs are an add-on to Medicare's base payments (DGME), and are continuously adjusted according to complex formulas.[26] Currently, IME payments increase by 5.5% for each 10% increase in the ratio of residents to hospital beds.[27] The breath of covered services also continuously expands. For example, IME payments now include rehabilitation, psychiatric services and, in certain jurisdictions, pure medical research[28] conducted at teaching hospitals.[29]

Because IME payments are an adjustment to DGME base payment rates, Congress chose to tie IME payments to the volume of Medicare patients

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23. MEDPAC REPORT 2010, *supra* note 2, at 109.

24. *Id*.

25. Andrew D. Ruskin, *Graduate Medical Education Reimbursement in a Changing Healthcare Payment Environment,* MORGAN, LEWIS & BOCKIUS LLP (Jan. 21, 2010), *available at* http://www.healthlawyers.org/Events/Programs/Materials/Documents/AMC10/ruskin.pdf.

26. 42 U.S.C. § 1395ww(d)(5)(B) (2006).

27. MEDPAC REPORT 2010, *supra* note 2, at 103, 109; *Indirect Medical Education (IME)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (last modified Apr. 10, 2013), http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME.html; *see generally* 42 C.F.R. § 412.105 (2012).

28. Costs covered under Medicare IME continuously expand as hospitals operating costs rise. *The Cost of Caring*, AM. HOSP. ASS'N (June 2012), www.aha.org/content/12/CostofCaring2012.pdf; Judith Graham, *Medicare to Cover More Mental Health Costs*, N.Y. TIMES (Dec. 27, 2013, 6:46 PM), http://newoldage.blogs.nytimes.com/2013/12/27/medicare-to-cover-more-mental-health-costs/ (noting that Medicare has begun to cover costs related to mental health treatment). Although the Patient Protection and Affordable Care Act (ACA) attempted to clarify what costs may be covered as IME, it instead created confusion concerning the definition of reimbursable non-patient care activities. *See, e.g.*, Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans*, 18 ELDER L.J. 213, 214-15 (2011) (suggesting that actual coverage will turn on specific, individual characteristics). For example, two recent federal cases, *Henry Ford Health System v. Department of Health and Human Services* and *University of Chicago Medical Center v. Sebelius,* may have split the courts over whether pure medical research may be a covered cost under Medicare. *See* MEDPAC REPORT 2010, *supra* note 2, at 103; Henry Ford Health Sys. v. Dep't of Health & Human Servs., 654 F.3d 660, 660 (6th Cir. 2011); Univ. of Chicago Med. Ctr. v. Sebelius, 618 F.3d 739, 745 (7th Cir. 2010).

29. *Henry Ford Health Sys.,* 654 F.3d at 662-63; *Univ. of Chicago Med. Ctr.*, 618 F.3d at 745.

seen at the hospital and to the number of residents staffing the hospital.[30] As is the case with DGME payments, the number of residents included in the resident-to-bed ratio is capped at 1996 levels.[31]

C. Non-Medicare Funding Sources

While Medicare is the largest single contributor to GME, state Medicaid programs also contribute more than $3 billion annually. [32] In addition, the Department of Veterans Affairs (VA) supports more than 9,000 full time equivalent (FTE) residents and allows more than 30,000 residents and fellows to rotate through its hospitals each year.[33] Similarly, the Department of Defense annually supports the education and training of approximately 3,000 residents.[34] The Children's Hospital Medical Education Program administered by the Health Resources and Services Administration (HRSA) also provides $300 million to teaching hospitals to support direct and indirect GME costs.[35] Finally, a small amount of Title VII[36] grants administered by the Health Resource and Services Administration (HRSA) also support residency programs in primary care and geriatrics.[37]

Many hospitals complain that GME funding is insufficient and must increasingly rely on third party funding, specifically state and private donors. Notably, the largest revenue sources for medical schools today are faculty practice and federal research grants and contracts.[38] These make up 39% and 20%, respectively.[39] Additional funding also comes from private donors, tuition, and support from affiliated teaching hospitals.[40]

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30. MEDPAC REPORT 2010, *supra* note 2, at 103.

31. *Id*.

32. Dower, *supra* note 4, at 2.

33. Matthew Schick, VA GRADUATE MED. EDUC., ASS'N OF AM. MED. COLLS. WEBSITE, https://www.aamc.org/advocacy/budget/va/74964/va_gme.html.

34. COUNCIL ON GRADUATE MED. EDUC., U.S. DEP'T OF HEALTH & HUM. SERVS., FINANCING GRADUATE MED. EDUC.IN A CHANGING HEALTH CARE ENVIRONMENT (FIFTEENTH REPORT), 38 (Dec. 2000), http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/fifteenthreport.pdf..

35. U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORT TO CONGRESS: CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUC. (CHGME) PAYMENT PROGRAM (2013) (showing CHGME appropriations since 2000).

36. Through Title VII Section 747, Congress funds the Primary Care Training and Enhancement Program. *See Title VII*, SOC'Y TEACHERS FAM. MED., http://www.stfm.org/advocacy/issues/VII.cfm (last visited July 18, 2013).

37. Ruskin, *supra* note 25; *see generally* Public Health Services Act of 1998 § 102(3), 42 U.S.C. § 293k (2006) (primary care); 42 U.S.C. § 294c (geriatric care).

38. COOKE, *supra* note 6.

39. *Id*.

40. *Id*.

PART II: GME PAYMENTS ARE NOT SUFFICIENT TO MEET THE UNITED STATES' CURRENT HEALTH CARE NEEDS AND LEAVE GAPS IN THE DELIVERY SYSTEM

A. Current Gaps in the U.S. Health Care System Despite Medicare's Payments

Despite over $9.5 billion in funding, the medical education system is not producing the number of physicians necessary to meet its evolving care needs.[41] As it stands now, there is a shortage of primary care physicians.[42] A 2005 report by the Council on Graduate Medical Education (COGME) projected that by 2020 the shortage of physicians will reach 85,000.[43] A 2008 study by the Association of American Medical Colleges projects that the shortage will increase to 124,000 physicians by 2025 across all specialties if regulations do not change.[44] One of the main reasons for the shortage is the baby boomers'[45] increased demand for medical care. Baby boomers total 78 million people,[46] yet only 40.2 million people (12% of the population) are aged 65 and older.[47] This 12% already accounts for 26% of physician office visits, 35% of hospital stays, 34% of prescriptions, 38% of emergency medical responses and 90% of nursing home use.[48] In the

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41. NAT'L RESIDENT MATCHING PROGRAM, RESULTS AND DATA 2011: MAIN RESIDENCY MATCH (Table 3), 7 (Apr. 2011), http://b83c73bcf0e7ca356c80-e8560f466940e4ec38ed51af32994bc6.r6.cf1.rackcdn.com/wp-content/uploads/2013/08/resultsanddata2011.pdf; Suzanne Sataline & Shirley S. Wang, *Medical Schools Can't Keep Up: As the Ranks of Insured Expand, Nation Faces Shortage of 150,000 Doctors in 15 Years*, WALL ST. J. (Apr. 12, 2010, 12:01 AM), http://online.wsj.com/article/SB10001424052702304506904575180331528424238.html.

42. Sataline, *supra* note 41 (2010).

43. COUNCIL ON GRADUATE MED. EDUC., U.S. DEP'T OF HEALTH & HUM. SERVS., PHYSICIAN WORKFORCE POLICY GUIDELINES FOR THE U.S., 2000-2020 (SIXTEENTH REPORT) at xvi and 44 (Jan. 2005), http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/sixteenthreport.pdf.

44. COUNCIL ON MED. EDUC., AM. MED. ASS'N, *Council on Medical Education Report 3-I-09: Securing Funding for Graduate Medical Education (Resolution 381, A-09)*, 8 (2009), http://www.ama-assn.org/resources/doc/council-on-med-ed/cme-report-3i-09.pdf (last visited Feb. 15, 2014).

45. Baby Boomers are children born in the 25 years after World War II. As of the publication date of this paper, people in the baby boomer generation are between the ages of 43-68. *Baby Boomer Generation Fast Facts*, CNN LIBRARY, http://www.cnn.com/2013/11/06/us/baby-boomer-generation-fast-facts/ (last visited Feb. 18, 2014).

46. Emily Sanderson, *The Rising Health Care Needs of Aging Baby Boomers*, TOP TEN REVIEWS (2010), http://medical-careers-review.toptenreviews.com/the-rising-health-care-needs-of-aging-baby-boomers.html (last visited Feb 18, 2014).

47. *Id*.

48. *Id*.

coming years, as more baby boomers reach age 65 and qualify for Medicare, their medical needs could exhaust the health care system.[49] To prepare for this demand, the United States needs more geriatric and ambulatory care facilities and more physicians skilled in geriatric care.[50]

The reasons for the current shortage of primary care physicians[51] are relatively simple: 1.) Medicare reimbursement rates incentivize hospitals to train specialists, and 2.) primary care physicians have lower lifetime earnings than specialized physicians.[52] As illustrated by a new study in the *Journal of Medical Care,* primary care physicians make roughly $4 million less than oncologists throughout their careers and $1.6 million less than general surgeons throughout their careers.[53]

1. Low Care Value: Lack of Care Coordination Among Providers

In its 2009 and 2010 reports, the Medicare Payment Advisory Commission (MedPAC) found that the quality of care offered by American physicians was not of high value.[54] Specifically, MedPAC felt that there is a single-minded treatment approach to care in America, which results in a lack of coordinated care across disciplines.[55]

MedPAC also identified interpersonal communication skills as a problem area.[56] The study revealed many providers did not effectively communicate with fellow providers, patients, and their families.[57] This resulted in confusion among the patient's family and confusion with fellow medical personnel about care treatment plans.[58] In addition, physicians were unable to effectively utilize new health information technologies, including

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49. *Id*.

50. Brian Bethel, *Boomer Health Scorecard Not as Bad as it Looks, Abilene Health Experts Say*, REPORTERNEWS (Feb. 8, 2013), http://www.reporternews.com/ news/2013 /feb/08/baby-boomer-health-scorecard-not-as-bad-as-it/.

51. *See* COUNCIL ON GRADUATE MED. EDUC., supra note 43, at xvi (Jan. 2005); *see also* David Blumenthal, *New Steam from an Old Cauldron–The Physician-Supply Debate*, 350 NEW ENG. J. MED. 1780, 1780-87 (2004).

52. Daniel Akst, *In Health Care, A Costly Pay Gap*, WALL ST. J. BLOG, (Oct. 5, 2010, 12:29 PM), http://blogs.wsj.com/ideas-market/2012/10/05/in-health-care-a-costly-pay-gap/.

53. *Id*.

54. MEDPAC REPORT 2009, *supra* note 3, at 18. Quality of care refers to both successful treatment of an illness and the handling of patients' emotional care needs during the treatment process. *See also* MEDPAC REPORT 2010, *supra* note 2, at 103.

55. *See* MEDPAC REPORT 2010, *supra* note 2, at 103.

56. MEDPAC REPORT 2009, *supra* note 3, at 23.

57. *See id*. at 23-24.

58. Amgad N. Makaryus & Eli A. Friedman, *Patients' Understanding of Their Treatment Plans and Diagnosis at Discharge*, 80 MAYO CLINIC PROC. 991, 992 (Aug. 2005), *available at* http://internal.medicine.ufl.edu/files/2012/07/5.17.04.-Help-patients-understand-their-hospitalizations.pdf.

electronic medical records and the electronic computer order entry systems.[59] Lastly, MedPAC found that physicians lack experience in nonhospital settings.[60] MedPAC identified this as a problem because the increased geriatric care needs of the baby boomer generation will require physicians to travel to their patients.[61]

2. Lack of Transparency: GME Funds Are Paid to Hospitals Rather Than to Physicians

GME payments are structured such that they are made directly to the hospital and not to the residents or faculty who incurred the costs.[62] When the hospitals receive payments from patients, insurers, or government programs, they often mix the funds into one large pool.[63] Afterwards, the administrators decide how to allocate the funds.[64] Thus, although billed and paid appropriately as either IME or DME costs, once funds are received by the hospital, there is no accountability system that requires that the funds be applied to the department from which they were incurred.[65]

A particularly unfortunate result of this system is an underfunding of residency programs.[66] Teaching hospitals have competing goals. In a price-competitive market economy, financial solvency and the need to attract patients must be balanced against providing resident learning opportunities. To bring in paying patients and subsequently increase their revenue, hospitals often invest in the latest technologies and patient-care services rather than in resident education.[67] Despite these measures, hospitals are increasingly finding themselves short of funds, especially now that a provision in the Budget Control Act of 2011, which took effect January 2013, automatically reduces Medicare payments to plans and providers by 2% as part of the sequestration.[68] There is also rising pressure on hospitals' revenue due to federal regulations that requires hospitals to provide medical

59. MEDPAC REPORT 2009, *supra* note 3, at 24.
60. *Id*. at 24-25.
61. *Id*. at 25-29.
62. COOKE, *supra* note 6, at 179.
63. *Id*.
64. *Id*.
65. *Id*.
66. COUNCIL ON GRADUATE MED. EDUC., U.S. DEP'T OF HEALTH & HUM. SERVS., GRADUATE MED. EDUC. CONSORTIA: CHANGING THE GOVERNANCE OF GRADUATE MED. EDUC. TO ACHIEVE PHYSICIAN WORKFORCE OBJECTIVES (NINTH REPORT), 23 (June 1997), http://www.hrsa.gov/advisorycommittees/ bhpradvisory/cogme/Reports/ninthreport.pdf.
67. *See* COOKE, *supra* note 6, at 164-65.
68. Sequestration was projected to reduce Medicare spending by $11 billion in fiscal year 2013. *See* HENRY J. KAISER FAM. FOUND., THE BUDGET CONTROL ACT OF 2011: IMPLICATIONS FOR MEDICARE, (Nov. 13, 2012), kaiserfamilyfoundation.files.wordpress.com/2013/01/8216-02.pdf.

treatment to all patients, including undocumented immigrants, the uninsured, and the poor.[69] A recent study surveying the finances of 3,861 hospitals found that over half were "technically insolvent" or "at risk of insolvency" without government funding and private donation.[70]

B. GME Funding Is Disproportionally Allocated Among the States

A recent study by researchers from the George Washington University School of Public Health and Health Services found that residency programs in the Northeast receive the largest portion of GME funding despite the fact this region also has the country's greatest doctor-to-population ratio.[71] As an example, 20% ($2 billion) of the nation's GME funds go to the state of New York while 29 states get less than 1% of the funding.[72] Shown another way, this staggering discrepancy results in Medicare GME contributing only $1.94 per resident of Montana, while the District of Columbia receives $172.85 for each of its residents.[73] The study's authors have noted that their research is important for two reasons: "First, it is well established that there is a positive association between the site of training and locale of practice. Second, GME's dependence on federal support raises legitimate concerns about distributional fairness in this form of public funding."[74]

PART III: THE AFFORDABLE CARE ACT'S REVISIONS TO DGME AND IME ARE NOT ENOUGH

Addressing, in part, many of the issues outlined in Part II of this Note, President Obama signed into law the Patient Protection and Affordable Care Act (ACA) in March 2010.[75] The Act revised GME funding provisions and

69. *See id*.; *see also* Jeffrey Rowes, *EMTALA: OIG/HCFA Special Advisory Bulletin Clarifies EMTALA American College of Emergency Physicians Criticizes It*, 28 J.L MED. & ETHICS 90, 90-91 (Spring 2000).

70. David Hamilton, *Are Half of Hospitals Insolvent? Not Exactly*, CBSNEWS (Apr. 30, 2008), http://www.cbsnews.com/8301-505123_162-33640047/are-half-of-hospitals-insolvent-not-exactly/.

71. Kathy Fackelmann, *Twenty Percent of Nation's Graduate Medical Education Funds go to New York While 29 States Get Less Than 1 Percent, Study Says*, GEO. WASH. SCH. PUB. HEALTH & HEALTH SERVS. (Nov. 4, 2013), https://sphhs.gwu.edu/content/twenty-percent-nation's-graduate-medical-education-funds-go-new-york-while-29-states-get.

72. *Id*.

73. Alison Ritchie, *Medicare Graduate Medical Education Funding Unevenly Distributed, Study Finds*, MED. ECON. (Nov. 15, 2013), http://medicaleconomics.modernmedicine.com/medical-economics/news/medicare-graduate-medical-education-funding-unevenly-distributed-study-finds.

74. *Id*.

75. Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010).

mandated medical coverage for most Americans.[76] The revisions to health care include increasing both the primary care residency positions and the availability of health care in rural America.[77]

A. Incentivize Primary Care Residency Positions in the ACA

Among its provisions, the ACA establishes a new program to incentivize hospitals to offer more primary care residency programs.[78] Beginning in 2011 and ending 2015, the program (Title III) will pay Qualified Teaching Health Centers (community based ambulatory patient care centers that operate primary care residency programs) up to $230 million for direct and indirect GME costs incurred by residents.[79]

Before the ACA, if a teaching hospital closed its residency program, positions were eliminated from the entire Medicare GME reimbursement program.[80] The result was that the number of GME residency positions available nationwide decreased with every hospital closure. Now, ACA Section 5506 preserves the number of residency slots available and creates a bidding system to redistribute those positions to other teaching hospitals.[81] However, if a functioning accredited teaching hospital fails to fill all of its residency positions because it, for example, downsizes its staff in order to save money, Section 5503 of the ACA cuts its Medicare GME payments for all unfilled residency positions.[82] Instead of receiving full DGME and IME payments for the residents it still has, deficient hospitals will only receive 65%, per physician, of the difference between what the payments would be

76. *See generally* 75 Fed. Reg. 71808 (2010); Mandated Medical Coverage for Most Americans, H.R. 3590-126, 111th Cong. (2010).

77. *See generally* H.R. REP. NO. 111-3590 (2010).

78. *Id*.

79. To avoid double payment issues in the teaching health centers, Medicare payments to qualified teaching health centers are considered in addition to payments made for traditional GME payments. Although DGME and IME payments to accredited teaching hospitals have been well established, the law currently does not clarify direct and indirect expenses for teaching health centers. *Id*.

80. Recall that as part of the Balanced Budget Act of 1997, the number of residency positions available at a teaching hospital was capped at the 1996 levels. Thus, when hospitals closed the overall number of Medicare sponsored residency positions in the United States shrank. *See also* Robert L. Phillips, Jr. et. al., *The Balanced Budged Act of 1997 and the financial health of teaching hospitals*, 2 ANN. FAMILY MED. 78 (Jan. 2004), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1466620/.

81. H.R. REP. NO. 111-3590.

82. *Resident Limit Redistribution Programs*, AM. ASSOC. MED. CS., https://www.aamc.org/advocacy/medicare/149758/resident_limit_redistribution_programs.html (last visited Mar. 28, 2014).

under a fully filled residency program and what the payments would be under the programs' existing staffing.[83]

These reforms reallocate unused primary care positions and incentivize hospitals to fill existing positions, yet in practice they have been unsuccessful in attracting more primary care physicians.[84] Simply increasing the availability of primary care residency positions does nothing to combat basic disincentives that discourage residents from choosing that specialty, nor does it address hospitals' reasons for not increasing their program size.[85] As an example, the ACA does not consider students' increased tuition costs, hospitals' increased costs of running teaching programs, or hospitals' increased overhead costs of providing charity care to the needy and to illegal immigrants.[86] Thus, because it fails to consider these factors, the ACA cannot be fully effective in increasing the number primary care doctors. Each factor will be considered in turn in order to determine its effect on the number of primary care doctors.

1. Effect of Increased Tuition Costs

In the last decade, the number of primary care residents has fallen[87] while at the same time student debt has increased dramatically. In 1998, according to the Association of American Medical Colleges (AAMC), the average student debt adjusted for inflation was $117,500 for medical school graduates.[88] By 2008, that number rose to $161,500.[89] The growing student debt, combined with the lower salaries primary care physicians receive, is likely a major disincentive which deters residents from selecting primary care specialties.[90]

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83. *Id*.; *see also Centers for Medicare and Medicaid Services Issues Proposed Changes to Medicare Graduate Medical Education Payments*, MCDERMOTT WILL & EMERY LLP, 3 (Aug. 4, 2010), http://www.mwe.com/info/news/wp0810b.pdf.

84. Carolyne Krupa, *Primary Care Work Force: Grants Target Perennial Plea for More Residents,* AM. MED. NEWS (Dec. 6, 2010), http://www.ama-assn.org/amednews/2010/12/06/prl21206.htm.

85. Jennifer Lubell, *Medical Students Urge Congress to Preserve GME*, AM. MED. NEWS (Feb. 15, 2013), http://www.ama-assn.org/amednews/2013/02/11/gvse0215.htm.

86. MCDERMOTT WILL & EMERY LLP, *supra* note 83.

87. *Strengthening Primary Care: Ensuring Access to Health Care Across Minnesota*, HEALTH REFORM MINN., http://mn.gov/health-reform/topics/workforce/strengthening-primary-care/index.jsp (last visited Nov. 1, 2013).

88. Krupa, *supra* note 84.

89. *Id*.

90. Sean Nicholson, *Barriers to Entering Medical Specialties Working Paper No. 9649*, NAT'L BUREAU ECON. RES., 14 (Sept. 2003), http://www.nber.org/papers/w9649 (last visited Jan. 31, 2012).

2. Effect of Increased Educating Costs

As previously mentioned, the ACA attempts to incentivize hospitals to fully utilize all residency positions by financially penalizing hospitals that do not fill all their slots.[91] This approach does not consider or address the rising costs of running a hospital. In 1996, the average cost of both educating a resident and developing and managing a medical education program was between $71,000-$93,000 per student per year.[92] In 2010, the total cost of this activity rose to be between $90,000-$118,000 annually.[93] In addition, studies have shown that university teaching hospitals are 44% more expensive to run than non-university teaching hospitals, which are in turn 14% more expensive to run than teaching hospitals..[94] There are several reasons for the rising cost of care for hospitals. First, the government *mandates* that both teaching and non-teaching hospitals write off much of their gross revenue to contractual allowances with insurance companies, charity care for illegal immigrants, needy Americans, and bad debts.[95] In 2005, hospitals wrote off about 62% of their gross revenues.[96] By 2009, the write-off percentage increased to more than 65%.[97] The resulting net revenues did not cover the costs of providing care, which rose about 7% per year during the study period, from $316.979 billion in 2005 to $411.660 billion in 2009.[98]

In sum, the data suggests that overall cost of running a hospital has increased every year while revenue has decreased.[99] Teaching hospitals bear this most acutely as, in addition to higher overhead, the cost of educating physicians has increased while Medicare reimbursement rates have remained relatively constant.[100] In the face of this crisis, the ACA Section 5503 nonetheless penalizes fiscally responsible teaching hospitals that do not fill

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91. H.R. REP. NO. 111-3590.

92. COOKE, *supra* note 6, at 177.

93. *Id*.

94. *See* Robert Mechanic, Kevin Coleman, & Allen Dobson, *Teaching Hospital Costs: Implications for Academic Missions in a Competitive Market*, 11 J. AM. MED. ASS'N 1015, 1015-19, (Sep. 16, 1998).

95. Thomas M. Schuhmann, *Can Net Income From Non-Patient—Care Activities Continue to Save Hospitals?,* HEALTHCARE FIN. MGMT. ASS'N (May 1, 2010), *available at* http://www.hfma.org/Templates/Print.aspx?id=20443.

96. *Id*.

97. *Id*.

98. *Id*.

99. J. L. Ashby, Jr. & C.K. Lisk, *Why do Hospital Costs Continue to Increase?*, 11 HEALTH AFFAIRS 134, (1992) http://content.healthaffairs.org/content/11/2 /134.full.pdf.

100. *Id*. at 141. *See generally* Jason Fodeman, *The New Health Law: Bad for Doctors, Awful for Patients*, INST. HEALTHCARE CONSUMERISM (Apr. 2011), http://www.theihcc.com/en/communities/policy_legislation/the-new-health-law-bad-for-doctors-awful-for-patie_gn17y01k.html.

residency positions that they cannot afford.[101] The ACA then withholds the funding upon which these same hospitals rely to stay solvent and competitive.[102] By addressing the lack of residency programs in this superficial way, the ACA forces hospitals to assume additional residency positions they often cannot afford or fill.

B. Increasing Medical Care in Rural Areas

In addition to attempting to incentivize primary care residencies, the ACA works to increase the availability of medical facilities in rural areas by mandating that 70% of the residency slots that are redistributed according to Section 5506 are given to hospitals in states with resident-to-population ratios in the lowest quartile (MT, ID, AK, WY, SD, NV, ND, MI, IN, PR, FL, GA, AZ).[103] In addition, 30% of redistributed slots must go to hospitals located in the ten states with the highest proportion of people living in health professional shortage and rural areas (LA, MS, PR, NM, SD, DC, MT, ND, WY, AL).[104] This plan of rural redistribution is not new. Implemented in 2005, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 redistributed nearly 3,000 residency positions among the nation's hospitals, largely as an attempt to train more primary care residents in rural areas. The outcomes of the 2005 redistribution hold potential lessons for the current redistribution and for any future GME reforms.[105] However, after analyzing the outcomes of that Act, a 2013 study found that out of 304 hospitals receiving additional positions, only twelve were rural, and they received fewer than three percent of all positions redistributed.[106] This begs the question of whether simply mandating rural residency positions and failing to reform GME payment systems is an effective way to bring more physicians to rural areas.

The ACA also recognizes an increasing need for non-traditional medical care due in part to the aging of the baby boomer generation. Sections 5504 and 5505 of the ACA attempt to encourage hospitals to provide residents with ambulatory training.[107] Both sections count all time spent by residents

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101. *Direct Graduate Medical Education (DGME)*, ASS'N AM. MED. CS., (Jan. 2014), http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/AcuteInpatientPPS/dgme.html (last visited Apr. 1, 2014).

102. *Id*.

103. MEDPAC REPORT 2010, *supra* note 2, 117-22.

104. H.R. REP. NO. 111-3590, at 539-40 (2010).

105. Candice Chen et. al., *The Redistribution of Graduate Medical Education Positions in 2005 Failed to Boost Primary Care or Rural Training*, 32 HEALTH AFFAIRS 102 (Nov. 2013), http://content.healthaffairs.org/content/32/1/102.abstract.

106. *Id*.

107. Ambulatory training involves training physicians in non-hospital settings such as homecare visits or outpatient clinics. MCDERMOTT WILL & EMERY, *supra* note 83, at 3.

in a non-provider setting towards DGME and IME costs if the hospital also incurs the costs of residents salaries and fringe benefits (DGME costs).[108] It remains to be seen whether Section 5504 and 5505 will actually increase ambulatory care. Studies have found that teaching sites for general internal medicine in ambulatory clinics have 36% higher operating costs than their nonteaching counterparts.[109] The higher costs imply the same issues as previously analyzed in Section A. Recent studies have shown that the operating costs associated with staffing ambulatory clinics with medical students and residents actually increases costs incurred by teaching centers by 24-36%. [110]

After three years in practice, the reforms in ACA have rendered negligible savings to Medicare.[111] Although these reforms may have measurable effects in patient care, they do not address the rising cost of education and educating physicians. As an alternative, Medicare could re-evaluate the fee for service schedules it pays for DGME and IME costs to reflect the current costs of treating patients.

PART IV: CHOOSING A REFORM OPTION: WHICH REFORMS MATCH THE CORRECT PURPOSE?

Inevitably, choosing a GME funding reform option becomes a highly political and polarizing topic. AAMC, the nation's largest physician medical interest group, supports both the GME Reform Act of 2012 (S. 1627) and the Resident Physician Shortage Act of 2011, as integral first steps to larger legislative reform.[112] To encourage effective usage of funds, MedPAC recommends reducing the IME payment adjustment schedule from 5.5% to 2.2% and redistributing the savings to qualified teaching health centers.[113] In contrast, President Obama's budget proposal for fiscal year 2013 cut IME funding by 10% over the subsequent ten years in order to

108. H.R. REP. NO. 111-3590, at 541 (2010).

109. *See* COOKE, *supra* note 6, at 177.

110. James R. Boex et al., *Measuring the Costs of Primary Care Education in the Ambulatory Setting*, 75 ACAD. MED. 419, 422 (2000).

111. MEDPAC REPORT 2010, *supra* note 2, at 103-16.

112. AAMC, *AAMC Applauds Resident Physician Shortage Reduction Act of 2011*, Press Release (Sept. 23, 2011); AAMC, *AAMC Applauds Introduction of Senate GME Residency Slot Measure*, Press Release (Sept. 30, 2011); *see also* Tim N. Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey*, ASS'N. OF AM. MED. COLLS., 5-7 (April 2010).

113. MEDPAC REPORT 2010, *supra* note 2, at 103-16.

balance the budget deficit.[114] This section evaluates each reform option in turn.

A. GME Reform Act of 2012 (S. 3201)

Introduced May 17, 2012 by Senators Jack Reed (D-RI) and Jon Kyl (R-AZ), the GME Reform Act increases IME funding transparency in an attempt to pin point specific areas of waste in the Medicare GME payment system.[115] To meet this goal, by 2015 the Secretary of Health and Human Services (HHS) will create and implement a program known as the IME Performance Adjustment Program (PAP).[116] PAP will evaluate patient care priorities (PCP).[117] PCPs have been pre-selected and include a survey of the quality of training provided to residents and the quality of care residents provide to patients.[118] To ensure fairness, PAP's specific evaluation methods will be developed and endorsed by an accredited organization such as the Accreditation Council for Graduate Medical Education (ACGME), teaching hospitals, and resident physicians.[119] PAP will submit its results to Congress and to the National Health Care Workforce Commission in an annual report.[120]

PAP will also evaluate PCPs and the overall effectiveness of resident training programs. To accomplish this, it will observe the diagnosis and management of Medicare patients (including the relevant costs and value of their diagnostic and treatment options), as well as the frequency and methods used to identify physician error, and the ways physicians amended those errors.[121] The HHS will then evaluate residents' ability to work in inter-professional and multidisciplinary care teams and assess their overall willingness and skill in patient care coordination.[122] Individual evaluations done by patients will also be vital under the PCP program. Specifically, patients will evaluate their overall experience based on medical and

114. *Proposed Federal Budget for FY 2013 Will Cut Finding for GME*, UNIV. OF FLA. HEALTH GRADUATE EDUC. HOUSE STAFF (Apr. 3, 2012), http://gme.med.ufl.edu/2012/04/03/proposed-federal-budget-for-fy-2013-will-cut-funding-for-gme/.

115. Graduate Medical Education Reform Act of 2012, S. 3201, 112th Cong. (2012);

116. ASS'N AM. MED. COLLS., *Bill Summary of Graduate Medical Education Reform Act of 2012 (S. 3201)*, https://www.aamc.org/download/300734/data/graduatemedicaleducationreformactof2012.pdf (last visited Aug. 12, 2014) (hereafter AAMC Bill Summary).

117. *Id*.

118. *Id*.

119. *Id*.

120. *Id*.

121. AAMC Bill Summary, *supra* note 116.

122. *Id*.

nonmedical factors, such as their physician's attitude and the attending physician's communication skills.[123]

To ensure payment transparency, the final report will include a breakdown of the DGME and IME payments made to each hospital.[124] It will also include the DGME costs incurred by each hospital (as reported on the annual Medicare Cost Reports).[125] The report will state the number of Full Time Equivalency residents at each hospital (both those counted and not counted for GME purposes), and other common factors contributing to higher patient care costs.[126] Factors may include the costs of uncompensated care, translators for disabled or non-English speaking patients, uncompensated clinical research, trauma and burn services, and overall financial losses associated with treating Medicaid patients.[127]

Beginning in 2017, each hospital that does not report patient care measures will have its IME payments reduced by 0.5 percent.[128] In 2018, IME payments will be reduced by up to 3% for hospitals that fail to achieve the new performance standards.[129] Conversely, hospitals that are successful in implementing the new performance standards may receive IME bonus payments.[130]

There are two main critiques of this plan. The first is that the transparency requirements do not go far enough.[131] Recall that Medicare payments are currently made directly to hospitals. Since there are few transparency standards, hospitals often pool Medicare payments with other payments making it is difficult to determine if GME payments go towards GME costs.[132] Despite this problem, S.3201 does not reroute GME payments away from hospital control.

The second critique is that PCP evaluations would hold physicians to impossible care standards.[133] Physicians would be evaluated on their patients' subjective feelings about overall care experience.[134] For example, negative evaluations could be given to physicians for not spending adequate

123. *Id*.
124. *Id*.
125. *Id*.
126. *Id*.
127. AAMC Bill Summary, *supra* note 116.
128. *Id*.
129. *Id*.
130. *Id*.
131. *Id*.
132. COOKE, *supra* note 6, at 179.
133. AAMC Bill Summary, *supra* note 116.
134. *See generally* Cheryl L. Damberg, *Physician Payment Reform: Designing a Performance-Based Incentive Program*, RAND CORP. (2012), *available at* http://www.rand.org/content/dam/rand/pubs/testimonies/CT300/CT389z1/RAND_CT389z1.pdf.

time with a patient or for lacking sufficient empathy. Proponents of this argument conclude it is unfair to hold physicians responsible for the subjective feelings of patients if they are also held to the high productivity levels that prevent them from spending adequate time with patients.[135]

To fill the care gap that high productivity requirements create, proponents propose the use of evaluating nurses or physician assistants on overall care experience rather than physicians.[136] Nurses generally provide the nurturing element of care.[137] They sit with patients, answer questions and provide the emotionally soothing element that is vitally important to patient recovery. Physician assistants and nurses also have more time to spend with patients and their employment cost to the hospital is lower.[138]

B. Physician Shortage Reduction and GME Accountability and Transparency Act (H.R. 6352)[139]

Introduced by Aaron Schock (R-IL) and Allyson Schwartz (D-PA), the Transparency Act focuses on increasing care available by increasing the overall number of Medicare-supported residency training positions. Additionally, the bill enhances GME transparency by mandating uniform evaluation standards similar to those in the 2012 Act.[140]

Just as in the 2012 Act, this bill requires a National Health Care Workforce Commission to submit a report identifying specialties where there is a shortage.[141] From this report, the Government Accountability Office would launch a study to recommend strategies for increasing health professional workforce diversity.[142]

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135. Matthew P. Manary et. al., *The Patient Experience and Health Outcomes*, 368 NEW ENG. J. MED. 201-03 (2013) *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1211775.

136. *See generally* JOANNE V. HICKEY & CHRISTINE A. BROSNAN, EVALUATION OF HEALTH CARE QUALITY IN ADVANCE PRACTICE NURSING (Margaret Zuccarini ed. 2012).

137. Sarah Breier-Mackie, *Medical Ethics and Nursing Ethics—Is there Really any Difference?*, 29 GASTROENTEROLOGY NURSING 182 (2006) *available at* http://www.nursingcenter.com/lnc/pdfjournal?AID=641332&an=00001610-200603000-00099&Journal_ID=&Issue_ID=.

138. Jeffrey C. Bauer, *Nurse Practitioners as an Underutilized Resource for Health Reform; Evidence-Based Demonstrations of Cost-Effectiveness*, AM. ASSOC. NURSE PRACTIONERS NEWS (2010), https://flanp.org/files/JBauer-nps-as-under-utilized-resource-AANP-7E1.pdf.

139. Resident Physician Shortage Reduction and Graduate Medical Education Accountability and Transparency Act, H.R.6352, 112th Cong (2012) (Transparency Act).

140. DOWER, *supra* note 4, at 7.

141. *Id*.

142. Transparency Act, *supra* note 139.

Between 2013-2017 this plan would add 15,000 new residency positions to certain Medicare accredited teaching hospitals.[143] At least half of the new slots must go to residency program specialties that the National Health Care Workforce Commission identifies as underrepresented, such as primary care.[144] While this plan has flaws and benefits similar to the GME Reform Act, it is specifically aimed at increasing primary care physicians.[145] The plan, however, fails to designate specific strategies for permanently attracting physicians to the rural and underserved communities that now have additional residency slots (see ACA Section 5506). Studies have shown that doctors tend to practice where they train. When personal motivation and mission-based values coincide with attractive salary and benefits, research indicates that physicians are more likely to serve underserved communities.[146] Simply creating positions in a rural or underserved community, as outlined in this plan, does not mean those positions will be fully staffed after a resident has completed his program.

C. MedPAC's Reduction in GME Payment Schedule

Concerned that IME payments reward hospitals for quantity of tests ordered rather than necessity of testing, the MedPAC suggested in its 2010 report that IME payments be contingent on a hospital's overall performance instead of on the current fee for service arrangements.[147] MedPAC also proposed reducing the IME adjustment schedule from 5.5% to 2.2%.[148] Recall that IME payments continuously adjust in order to accurately reflect the realized costs of treating Medicare patients.[149] MedPAC's analysis

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143. *Id*.

144. *Id*.

145. *Id*.

146. Kara Odom Walker, et al., *Recruiting and Retaining Primary Care Physicians in Urban Underserved Communities: The Importance of Having a Mission to Serve*, 100 AM. J. PUBLIC HEALTH 2168, (Nov. 2010), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951944/.

147. MEDPAC REPORT 2010, *supra* note 2, at 103.

148. ProPAC and the Physician Payment Review Commission (PPRC) merged to create MedPAC in 1997. At the time of the Mitchell Act ProPAC was a separate entity. Oliver Fein, *Funding Graduate Medical Education in The Year of Health Care Reform: A Case Study of a Health Issue on Capitol Hill, in* INFORMATION TRADING: HOW INFORMATION INFLUENCES THE HEALTH POLICY PROCESS 40, 42 (National Academies Press 1997).

149. *See generally* Karen S. Fisher & Andrew D Ruskin, AM. HEALTH LAWYERS ASS'N ACADEMIC MEDICAL CENTERS PROGRAM, Legal Issues Affecting Academic Med. Ctrs. and Other Teaching Inst., *Graduate Medical Education Reimbursement in a Changing Healthcare Payment Environment: Emerging New Issues and Persistent Old Ones*. (Washington, D.C., Jan. 20-21, 2010), http://www.healthlawyers.org/Events/Programs/Materials/Pages/AMC10.aspx.

suggests that the IME adjustment schedule substantially overestimates the relationship between teaching intensity (educating and supervising residents) and costs per Medicare case (operating and capital costs combined).[150] The research concludes that the ratio should only reflect a 2.2% increase for every 10% increase in the ratio of residents to hospital beds rather than the aforementioned 5.5% increase.[151] If the findings are accurate, the current IME adjustment is set at more than twice what can be empirically justified.[152] MedPAC's suggested reduction is estimated to save Medicare $3.5 billion in unrealized IME payments.[153]

Calls to reduce the GME payment adjustment schedules are not new. In 1994, the Labor and Human Resources Committee created the Mitchell Bill through which they tried to reduce the IME adjustment factor from what was then 7.7% to 5.2%.[154] At that time, the Prospective Payment Assessment Commission (ProPAC)[155] also advocated reducing the indirect GME adjustment factor from 7.7% to 5.2%. None of these reform options were implemented due to a lack of sufficient political support.[156] Specifically, Senator Moynihan (D-NY) refused to endorse the plan.[157] He felt that cutting GME funding would adversely impact Ney York's ability to train the physicians his state demanded.[158] Ultimately however, the Senate Finance Committee passed minor changes to cut indirect GME by $9.9 billion over seven years by reducing the indirect GME adjustment factor from 7.7% to 4.5%.[159]

Opponents to MedPAC's fee for service level reduction plan are numerous. Many physician groups and individual physicians balk at the prospect of receiving even less reimbursement from Medicare.[160] A Bloomberg study released in 2012 found that cutting IME from 5.5% to 2.2% would lead to a total *economic* loss of $10.9 billion.[161] The study also

150. Health Security Act, S. 1757, 103rd Cong. (1993); Fein, *supra* note 148 at 35-45
151. *Id*.
152. MEDPAC REPORT 2010, *supra* note 2, at 103-16.
153. *Id*.
154. Fein, *supra* note 148, at 40, 42.
155. *Id*.
156. *Id*. at 42.
157. Health Security Act, S.1757, 103rd Cong. (1993); Fein, *supra* note 148, at 35-45.
158. *Id*.
159. *Id*. at 45-46.
160. BRIAN RYE, BLOOMBERG GOVERNMENT STUDY: ASSESSING THE IMPACT OF POTENTIAL CUTS IN MEDICARE DOCTOR-TRAINING SUBSIDIES 18 (2012); *Proposed Reductions in Medicare IME Payments to AAMC Teaching Hospitals; National and State Economic Impacts*, ASSOC. AM. MED. COLLS. (Feb. 2011), https://www.aamc.org/download/253360/data/trippumbach.pdf.
161. *Id*.

predicts the reduction would eliminate $653 million in tax revenue.[162] Among physicians and hospitals these reductions are extremely unpopular.

D. Obama's Fiscal Plan for 2013 and the Simpson-Bowles Committee Recommendations

In February of 2010, President Obama created a commission to study, among other issues, the problems facing health care.[163] The Simpson-Bowles Committee, recommended limiting hospitals' DGME payments to 120% of the national average salary paid to residents in 2010.[164] This number would be annually updated to reflect the Consumer Price Index (CPI).[165] Like MedPAC, the committee recommended reducing the IME payment adjustment schedule from 5.5% to 2.2%.[166] The Committee estimated that the reduction would save Medicare $6 billion in 2015 and $60 billion by 2020.[167]

President Obama's fiscal plan for 2013 effectuated certain Simpson-Bowles Committee recommendations and cuts Medicare IME payments by 10%.[168] If ratified, this would equate to a $9.7 billion cut in Medicare payments over the next 10 years.[169] Additionally, the plan eliminates most GME funding to residents training at pediatric hospitals.[170] In total, the Children's Hospital GME program would also be cut by 67% ($177 million).[171]

Opponents to this cut, specifically the AMA, the majority of teaching hospitals, and many physicians, argued that slashing funding would only increase the current shortage of primary care physicians because hospitals will be forced to eliminate residency slots in order to save money.[172] The

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162. *Id*. at 13.

163. *Simpson-Bowles Facts Summary*, THEPOLITICALGUIDE.COM http://www.thepoliticalguide.com/Issues/Simpson-Bowles/ (retrieved Dec. 18, 2012).

164. *Id*.

165. *See* BIPARTISAN POL'Y, *Better Align Graduate Medical Education Payment with Patient Care Costs: Obama's Proposal*, *in* RECOMMENDATIONS TO THE JOINT SELECT COMMITTEE 10 (one way to achieve a new $1.2 trillion in savings for step 2).

166. *Id*. at 13.

167. *Id*.

168. OFFICE OF MGMT. & BUDGET, FISCAL YEAR 2013 BUDGET 34 (Feb. 2012), http://www.languagepolicy.org/documents/FY13%20USED%20summary%20request.pdf (last visited Oct. 16, 2012).

169. Sarah Mann, *Proposed Federal Budget Cuts GME, Freezes NIH Funding*, ASSOC. AM. MED. CS. REP. (Mar. 2012), https://www.aamc.org/newsroom/reporter/march2012/276736/budget.html.

170. OFFICE OF MGMT. & BUDGET, *supra* note 168.

171. Mann, *supra* note 169.

172. Recall that if residency slots are not filled the ACA cuts a hospital's entire reimbursement program is by 65% of what it would be if all the slots were filled. *See*

AMA's workforce study projects that these cuts to GME would result in an additional shortage of 90,000 doctors in the next 10 years.[173] Alternatively, if hospitals cannot eliminate the slots because of compliance with ACA Section 5503, the hospitals may instead face insolvency.

PART V: RECOMMENDATIONS

This article recommends the following items as a guideline for legislators planning to reform Medicare funded GME: 1) increasing GME funding and/or increasing hospitals' fee for service arrangements with private insurers while preserving the current government funded GME levels, 2) lifting the residency caps on available residency positions, 3) evaluating physicians on criteria that reflects a consensus among physicians and the scientific community rather than among politicians, 4) re-routing government Medicare GME payments to residency programs, and 5) reforming the DMGE and IME payment schedule to encourage a more fair allocation of funding among the states. These guidelines should not be considered a complete resolution to the issues outlined above, but rather as the basis of any new reform plan.

A. Reform GME Funding

Because increased access to medical care directly serves the public, public funding should continue to be used to temper the increased demand for physicians.[174] A study conducted by the AAMC in February 2011 estimated that the cuts to GME proposed by the Simpson-Bowles Commission would result in a job loss of more than 72,600 full-time residency positions nationally.[175] Many states, such as California, already have an across the board physician deficit.[176] Consequently, if funding is reduced, teaching hospitals will be unable to train what is already an insufficient number of

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generally Heather Perlberg, *Doctor Shortage Looms Amid Hospital Funding Gap*, BLOOMBERG (Oct. 5, 2011), http://www.bloomberg.com/news/2011-10-05/doctor-shortage-looms-as-teaching-hospitals-fight-for-funding.html.

173. Mann, *supra* note 169.

174. Adepeju L. Gbadebo & Uwe E. Reinhardt, *Economists on Academic Medicine: Elephants in a Porcelain Shop?* HEALTH AFFAIRS, http://content.healthaffairs.org/content/20/2/148.full#xref-ref-7-1 (last visited Feb. 2013).

175. AM. HOSP. ASS'N, *Graduate Medical Education Factsheet*, 1 (Apr. 22, 2014), http://www.aha.org/content/12/fs-gme.pdf.

176. Graduate Med. Educ., *Training Physicians: Medicare Support Provides Vital Funding to Train Our Doctors and Maintain Patient Access*, UNIV. CAL. S.F. (Jun 27, 2011), https://www.ucsf.edu/sites/default/files/fields/field_insert_file/news/gmecase.pdf; Michael J. Mishak, *State Lacks Doctors to Meet Demand of National Healthcare Law*, L.A. TIMES (Feb. 9, 2013), http://www.latimes.com/health/la-me-doctors-201 30210,0, 1509396.story.

physicians entering the work force.[177] This decrease in new physicians, coupled with an increase in demand for their services caused in part by the ACA and the aging of the baby boomer generation, will have an adverse effect on public access to medical care.[178] Therefore, GME funding should be reformed rather than cut.

Medicare's fee for service reimbursement rate should instead be increased such that DGME rates reflect current teaching and care costs. Many argue that current budget constraints preclude an increase in Medicare's payment schedules. As an alternative, the schedules for private payers, such as insurance companies, could be increased to make up the difference.[179] By increasing the Medicare payment schedules of insurance companies and holding government financed GME re-imbursement rates constant, residency programs could avoid serious budgetary shortfalls.

B. Lift the Residency Caps and Allow GME Reimbursement Levels to Reflect the Actual Costs of Training Residents

The current cap on the number of residency positions that qualify for GME payments prohibits teaching hospitals from adequately responding to the changing health care needs of their communities.[180] For this to change, the public would have to wait for Congress to enact new legislation.[181] As a result of this slow political process, the cap disproportionately harms communities formed after the cap was instituted because they must wait for Congress to vote on legislation.[182] Further, the cap also over-allocates residency positions to communities that have shrunk since the cap was created in 1996. Removing the residency restrictions would add fluidity to the system and will allow the market to dictate how many and in which communities residents should be trained.[183]

Opponents to lifting the restrictions remind reformers of the original purpose of the caps. Before Congress instituted the caps, too many students studied medicine resulting in an oversupply of physicians, which the

177. Perlberg, *supra* note 172.

178. *See* Rich, *supra* note 1, at 283-92.

179. Damberg, *supra* note 134.

180. Rich, *supra* note 1, at 283-92.

181. *Resident Limits Impede Teaching Hospitals' Educational Mission*, ASSOC. AM. MED. COLLS., https://www.aamc.org/advocacy/gme/276130/residentcaps.html (last visited Feb. 1, 2013).

182. *Medicare Resident Limits ("Caps")*, ASSOC. AM. MED. CS, https:// www.aamc.org /advocacy/gme/71178/gme_gme0012.html (last visited July 23, 2013).

183. John Q. Young & Janet M. Coffman, *Overview of Graduate Medical Education Funding Streams, Policy Problems, and Options for Reform*, 168 WEST J. MED. 428 (1998), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1304986/pdf /westjmed00332-0138.pdf.

government was then forced to subsidize through GME payments.[184] The hypothesis was that the oversupply contributed to the rising costs of care.[185] To assuage the legitimate fears of oversupply and a consequential rise in the cost of medical care, Congress must reform DGME and IME reimbursement levels in conjunction with removing the residency caps. By restricting the aggregate subsidy each hospital receives rather than the number of positions, the government reduces unnecessary expenditures on training, such as subsidizing oversupplied specialties, and leaves the number of actual residency positions to market forces.[186]

The aggregate subsidy from DGME and IME must accurately reflect the total costs of running a residency program at a teaching hospital. Currently, the DGME reimbursement level is held at the 1984 costs of providing care and is increased each year for inflation based on the CPI.[187] To its detriment, the details of this reimbursement schedule are not standardized nor does the schedule reflect the current costs of care. [188] Accordingly, it must be updated to reflect actual costs incurred by a hospital and must reflect one standardized accounting practice.[189]

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184. THE NATION'S PHYSICIAN WORKFORCE: OPTIONS FOR BALANCING SUPPLY AND REQUIREMENTS, INST. OF MEDICINE 77 (Nat'l Academies Press 1996), *available at* http://www.nap.edu/openbook.php?record_id=5111; *see also Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century*, CENT. HEALTH PROFESSIONS (1995), *available at* http://futurehealth.ucsf.edu/Public/Publications-and-Resources/Content.aspx?topic=Critical_Challenges_Revitalizing_the_Health_Professions_for_the_Twenty_First_Century; *see also Shifting the Supply of Our Health Care Workforce: A Guide to Redirecting Federal Subsidy of Medical Education*, CENT. HEALTH PROFESSIONS (1995), *available at* http://www.worldcat.org/title/shifting-the-supply-of-our-health-care-workforce-a-guide-to-redirecting-federal-subsidy-of-medical-education/oclc/609221415.

185. *Id*.

186. Young & Coffman, *supra* note 183.

187. Karen Matherlee, *Federal and State Perspectives on GME Reform Issue Brief No. 764*, NAT'L HEALTH POL'Y FORUM (June 2001), *available at* http://www.nhpf.org/library/issue-briefs/IB764_GMEReform_6-22-01.pdf; *see also* Joseph P. Newhouse & Gail R. Wilensky, *Paying for Graduate Medical Education: The Debate Goes on*, 20 HEALTH AFFAIRS 142 (Mar./Apr. 2001), *available at* http://content.healthaffairs.org/content/20/2/136.full.pdf.

188. Thomas R. Oliver, Atul Grover, & Philip R. Lee, *Variations in Medicare Payments for Graduate Med Educ. in California and Other States*, CAL. HEALTH CARE ORG. 16 (June 2001), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/V/PDF%20VariationsInMedicarePaymentsForGME.pdf.

189. Barbara Wynn, et. al., Alternative Ways of Financing Graduate Medical Education, RAND Health Working Paper 123-127 (May 2006) *available at* http://aspe.hhs.gov/health/reports/06/AltGradMedicalEdu/report.pdf (last viewed Nov. 10, 2012).

C. Create Clear, Fair Methods to Evaluate the Effectiveness of GME and Utilize NPs and PAs to Fill Patient Communication Gaps and Patient Care Shortcomings

Despite the substantial cost of care in the United States, patients are consistently disappointed with the quality of care they receive.[190] This finding is largely true because physicians' extremely high productivity requirements disallow them from spending extensive amounts of time listening to chief complaints and explaining treatment plans to patients.[191] The average primary care physician is responsible for 2,300 patients but is only able to allocate fifteen minutes of their time per patient.[192] Further, in those fifteen minutes they only spend on average 1.3 minutes conveying crucial information about the patient's condition and treatment.[193]

To retain high productivity statistics, Allied Health Professionals (AHPs)[194] should assume certain lower level responsibilities typically reserved for physicians. Specifically, Physician Assistants could independently perform routine, uncomplicated procedures in lieu of physicians.[195] To increase overall care satisfaction, Nurse Practitioners, Registered Nurses, or Licensed Practical Nurses should be responsible for nurturing patients, communicating with their families, and grief counseling. These professionals: 1) have the additional time to spend with the patient and to respond to their needs, and 2) they cost significantly less to both train and employ.[196]

To increase the quality of care provided by physicians, overall care should be evaluated according to standards created by the entire scientific community, including physicians. These evaluations should only consider procedures that are based on scientific evidence and that have a measurable effect on patient outcomes. As stated in a current report to Congress,

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190. Importantly, patients are not disappointed with the outcome of their procedures but they do have negative feelings towards the overall care experience. MEDPAC REPORT 2009, supra note 3, at 23-4.

191. Shannon Brownlee, *The Doctor Will See You—If You're Quick*, DAILYBEAST.COM (published Apr. 16, 2012, 12:00 AM; updated Apr. 19, 2012, 1:30 PM), http://www.thedailybeast.com/newsweek/2012/04/15/why-your-doctor-has-no-time-to-see-you.html.

192. *Id*.

193. *Id*.

194. AHPs are either physician assistants or nurse practitioners.

195. Michael J. Mishak, *State Lacks Doctors to Meet Demand of National Healthcare Law*, L.A. TIMES (Feb. 9, 2013), http://www.latimes.com/health/la-me-doctors-20130210,0,1509396.story.

196. Liz Kowalczyk, *New Cost-Control Law Expands Role of Physician Assistants*, BOS. GLOBE (Sept. 17 2012), http://www.bostonglobe.com/lifestyle/health-wellness/2012/09/16/comparing-training-for-physician-assistants-nurse-practitioners-doctors/g3RYzKuRGbELvYtzZLQGaJ/story.html.

developing these standards requires "careful review of the scientific evidence to identify areas that define high quality care . . . vetting the evidence and concepts with clinical expert panels, specification of the concept using various data sources . . . and finalizing the specification for uniform application across physicians in different settings."[197] The process to develop the standards should also undergo peer review, meaning that the "work of the measure developers and the clinical panels should be published in clinical journals or in other publications that rely on a similar review process."[198] This type of review program ensures that physicians are able to give their invaluable insights. Such insights include which patients should be excluded from care measures, what is a reasonable performance target, and the location of performance gaps.

Hospitals may object to this plan on two fronts: 1) They believe that patient care will decrease because AHPs are not qualified to take on physicians' roles and 2) their overall Medicare collection rates will decrease because AHP reimbursement rates are lower than physicians' rates.[199] While the first objection is valid, it can be circumvented with careful planning. It is therefore extremely important that hospitals take time to differentiate those procedures that can be safely performed by AHPs, and those that must be performed by physicians. The result predicted by the second objection remains to be seen. Although less Medicare money will go to physicians' billable hours, a hospital may still receive high reimbursement because, on average, it takes three midlevel practitioners to replace each resident.[200] In addition, AHPs lower salaries as compared to physicians may help to make up for some the difference in hospitals' lost revenue.

D. Reallocate GME Payments to Resident Programs and Demand Transparency

Medicare GME payments are not allocated appropriately because they are not tracked once the hospital receives them to ensure they are used for the procedure for which they were billed.[201] Funding currently goes to hospital administrators who are motivated to use the funds for non-educational

197. Damberg, *supra* note 134.

198. *Id*.

199. *Fact Sheet: Medicare Reimbursement*, AM. ASSOC. NURSE PRACTITIONERS (2011),http://www.aanp.org/legislation-regulation/federal-legislation/medicare/68-articles/325-medicare-reimbursement.

200. Barbara Green & Tim Johnson, *Replacing Residents with Midlevel Practitioners: A New York City-Area Analysis*, 14 HEALTH AFFAIRS 194 (Summer 1995), *available at* http://www.ncbi.nlm.nih.gov/pubmed/7657240.

201. Frederick M. Chen et. al., *Accounting for Graduate Medical Education Funding in Family Practice Training*, 34 FAM. MED. 663 (2002), *available at* http://www.stfm.org/fmhub/fm2002/oct02/re1.pdf.

purposes.[202] In a national survey of 328 family practice residency programs, more than half of the programs that responded to GME questioning did not know how much Medicare GME funding was allocated to them by their sponsoring hospital.[203] The same study revealed that the family practice programs in hospitals with other residency programs were allocated significantly less DGME than the amount paid by Medicare.[204] To encourage transparency and better budgeting, the residency program that incurs the Medicare payment should receive the GME payment. New regulations that track spending and place the funds in the hands of the residency program, such as the GME Reform Act of 2012 and S. 1697, are needed in order to pin point problem areas.

CLOSING THOUGHTS

Despite the unfavorable economic climate currently affecting the federal government's budget, GME remains an important tool for responding to the changing medical needs of the public. The recommendations throughout this paper are critical first steps for any successful legislation that aims to reform Medicare GME. Chief among those suggestions is that hospitals adopt greater GME funding transparency and that Congress acts to remove the 1996 residency caps. In the coming months and years, Congress must revisit the DGME and IME payment schedules and ensure that their revisions accurately reflect the actual costs incurred by teaching hospitals. This will require additional review of state and regional assessments of health care costs. If such actions are not taken, the increasing demands for medical care will far outstrip America's system for supplying physicians.

202. Non-educational purposes are vital concerns as often administrators must work especially hard to maintain hospital solvency.

203. Chen, *supra* note 201, at 665-67. 160 family practice programs responded to GME questioning. *Id*.

204. *Id*.