COUNCIL ON GRADUATE MEDICAL EDUCATION

7TH REPORT

JUNE 1995

COGME 1995 PHYSICIAN WORKFORCE FUNDING RECOMMENDATIONS FOR DEPARTMENT OF HEALTH AND HUMAN SERVICES' PROGRAMS

- HEALTH CARE FINANCING ADMINISTRATION - MEDICARE
- PUBLIC HEALTH SERVICE - PHYSICIAN EDUCATION
  - PRIMARY CARE RESEARCH

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Executive Secretary

COGME
Council on Graduate Medical Education

AUG 25 1995

Dear Colleague:

We are pleased to transmit to you the Seventh Report of the Council on Graduate Medical Education. This report contains specific recommendations to the Department of Health and Human Services (DHHS) and Congress for the prudent investment of public funds to better match the physician workforce with its health care needs. The proposals specifically address Medicare's direct and indirect graduate medical education (GME) payments (currently $6 billion annually) and the $500 million allocated through the Public Health Service (PHS) towards targeted physician education and primary care research goals.

COGME considers the analyses and recommendations in this report to be extremely topical and timely, given that Congress is currently considering significant reductions in Medicare GME payments and in key PHS workforce programs. The Council has therefore authorized the dissemination of the Seventh Report prior to the release of its Fifth Report, covering women and medicine, and its Sixth Report, covering managed health care issues.

In targeting federal funding for medical education, COGME suggests that the nation should attain the following goals:

1. Decrease the number of specialists trained.
2. Modestly increase the number of generalist physicians trained and improve the quality of primary care teaching.
3. Increase minority representation in medicine.
4. Improve physician geographic distribution.
5. Train more physicians in ambulatory and managed care settings.

Moreover, in making its recommendations to Congress and the DHHS Secretary, COGME identified the following principles:

1. Target medical education funding to physician workforce needs.
2. Provide options for budgetary savings that promote physician workforce goals.
3. Simplify and consolidate DHHS medical education financing and minimize regulation and micromanagement.
4. Provide incentives to expand education in primary care, ambulatory, and managed care settings.
5. Assist academic medical centers and teaching hospitals during the difficult transition.

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Based upon these goals and principles, the Seventh Report summarizes the relevant DHHS authorities within the Health Care Financing Administration (HCFA) and PHS and contains a consolidated, coordinated, and targeted set of legislative recommendations. They include:

- **Continued payments of Medicare GME funding of U.S. medical school graduates at current funding but reduced payments for international medical graduate residents.**
- **Targeted incentives for generalist physician training and increased teaching in non-hospital settings.**
- **Transition programs to assist IMG resident-dependent institutions.**
- **Utilizing the DME and IME components of the Average Adjusted Per Capita Cost (AAPCC) from Medicare capitation rates specifically for GME.**
- **Demonstration projects to foster the growth of consortia to manage medical education policy and financing.**
- **Reauthorizing the National Health Service Corps, Title VII (Health Professions Education), and primary care research, all at 1995 pre-recision appropriated levels.**
- **Consolidating Title VII programs and including the National Health Service Corps in the consolidation.**
- **Funding Title VII educational programs that have demonstrated effectiveness or the high likelihood of achieving specified outcomes.**
- **Reauthorizing the Council on Graduate Medical Education.**

COGME believes that the set of recommendations contained in the Seventh Report, if implemented, will provide for the prudent investment of public funds for training physicians in the right settings, specialties, and skills needed to meet the health needs of Medicare beneficiaries and the general public. Help will also be provided to academic medical centers and their teaching hospitals in restructuring.

If you have any questions or comments, please contact either me or F. Lawrence Clare, M.D., M.P.H., COGME Acting Executive Secretary, at Room 9A-21, 5600 Fishers Lane, Rockville, Maryland 20857. Thank you for your interest.

Sincerely,

David A. Kindig

David A. Kindig, M.D., Ph.D.

PREVIOUS REPORTS

Since its establishment, COGME has submitted or is in the process of completing the following reports to Congress:

- **First Report of the Council,** Volume I and Volume II (1988).
- **Second Report:** The Financial Status of Teaching Hospitals and the Underrepresentation of Minorities in Medicine (1990).
- **Scholar in Residence Report:** Reform in Medical Education and Medical Education in the Ambulatory Setting (1991).
- **Third Report:** Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century (1992).
- **Fourth Report:** Recommendations to Improve Access to Health Care Through Physician Workforce Reform (1994).
- **Fifth Report:** Women and Medicine (late 1995).
- **Sixth Report:** Managed Health Care: Implications for the Physician Workforce and Medical Education (late 1995).

SUMMARY OF RECOMMENDATIONS ON MEDICARE AND PHS PROGRAMS

MEDICARE

1. Continue to pay Medicare DME and IME for all residents who are graduates of US medical schools, but gradually reduce DME and IME for international medical graduate residents to 25 percent of the 1995 levels.

   (Estimated budget savings for 1996: $66 million in DME, $170 million in IME. Savings for 1996 - 2000: $1.07 billion in DME, $3.09 billion in IME.)

2. Provide incentives for generalist training and increased teaching in non-hospital settings.

   (Estimated budget savings for 1996: $37 million in DME, $452 million in IME; Savings for 1996-2000: $263 million in DME, $4.14 billion in IME.)

   a. DME and IME payments would be made for physician resident time spent in all nonhospital settings, to remove the disincentive for educational programs in such key nonhospital settings as physician offices, group practices, community health centers, and managed care facilities. Funding would follow the resident to his or her site of training.

   b. DME and IME payments for generalist residents in their first three years would be upweighted to 125% to enhance primary care teaching capacity. DME and IME would be downweighted to 75% for nongeneralist positions for the lesser of five years or the training required for initial board certification.

   c. All positions after the lesser of five years or the training required for initial board certification would be weighted at 50% for both DME and IME.

   d. IME calculations would not be allowed to increase if the hospital's inpatient bed capacity decreases.

   Estimated budget savings for the combination of Recommendations Nos. 1 and 2:

   1996: $92 million in DME, $510 million in IME.

   1996-2000: $1.20 billion in DME, $6.13 billion in IME.

3. Establish a transition program to assist institutions providing essential services which are dependent on IMG residents.

4. Identify and remove the DME and IME components of the Average Adjusted Per Capita Cost (AAPCC) from Medicare capitation rates and utilize these funds specifically for GME purposes.

5. Create demonstration projects to foster the growth of consortia to manage medical education policy and financing.

PUBLIC HEALTH SERVICE

1. Reauthorize, at 1995 pre-recision appropriated levels, the National Health Service Corps, Title VII (Health Professions Education), and primary care research (estimated budget impact: current appropriation level of approximately $493 million).
2. Consolidate Title VII programs and include the National Health Service Corps in the consolidation as recommended in the President's fiscal year 1996 Budget Proposals and the Health Professions Education Consolidation and Reauthorization Act of 1995 (S. 555).
3. Title VII educational programs which are funded either should have demonstrated effectiveness, or through program design should demonstrate a high likelihood of achieving specified outcomes. Priority should be given to those primary care training programs which place a high percentage of graduates in primary care practice, in rural communities, and in underserved urban and rural areas.
4. Reauthorize the Council on Graduate Medical Education (COGME) as recommended in the President's fiscal year 1996 Budget Proposal and the Health Professions Education Consolidation and Reauthorization Act of 1995 (S. 555).

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COGME 1995 Physician Workforce Funding Recommendations for Department of Health and Human Services' Programs

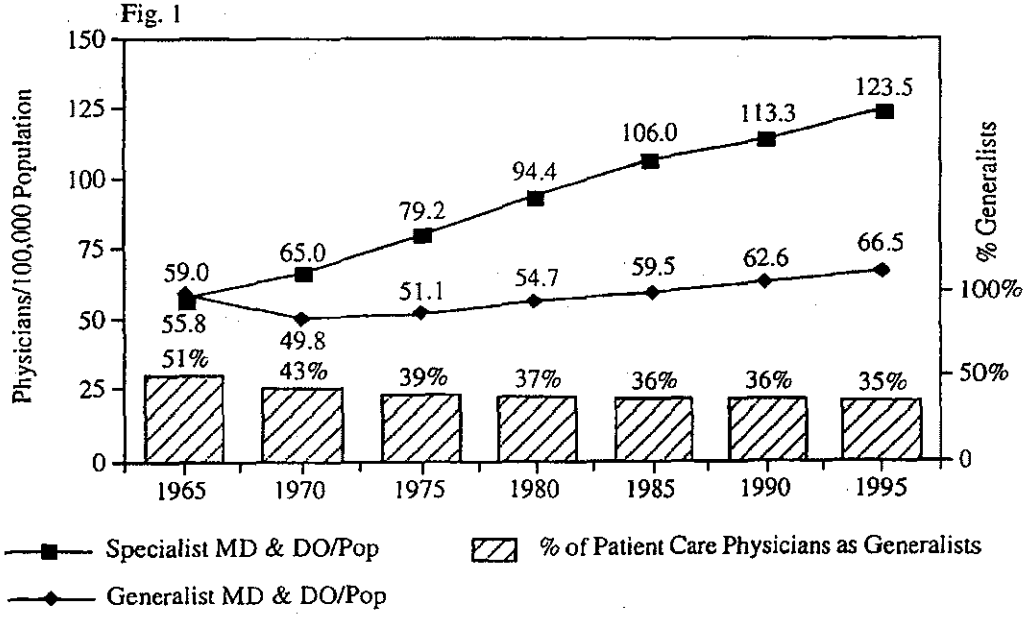
The purpose of this COGME report is to recommend to the Department of Health and Human Services (DHHS) and Congress how current public funds can be invested prudently to better match the physician workforce with its health care needs. The proposals specifically address Medicare's direct and indirect graduate medical education (GME) payments (currently $6 billion annually) and the $500 million allocated through the Public Health Service (PHS) towards targeted physician education and primary care research goals.

Congress is considering significant reductions in Medicare GME payments and in key PHS workforce programs, such as Title VII and the National Health Service Corps. To the extent Medicare GME cuts are made, COGME believes that available funding should be targeted to train physicians in the right settings, specialties, and skills needed to meet the health needs of Medicare beneficiaries and the general public. Help should also be provided to academic medical centers and their teaching hospitals in restructuring.

COGME's major goals are to slow the growth in the supply of physician specialists, to increase the relative proportion of generalist and minority physicians, and to improve geographic distribution. Figure 1 displays the rapid growth in physician supply during the last 25 to 30 years. Most of the increases have come from the specialties while the generalist-to-population ratio has remained relatively stable.

The Ratio of Specialist Physicians to Population Has More Than Doubled Since 1965

Fig. 1

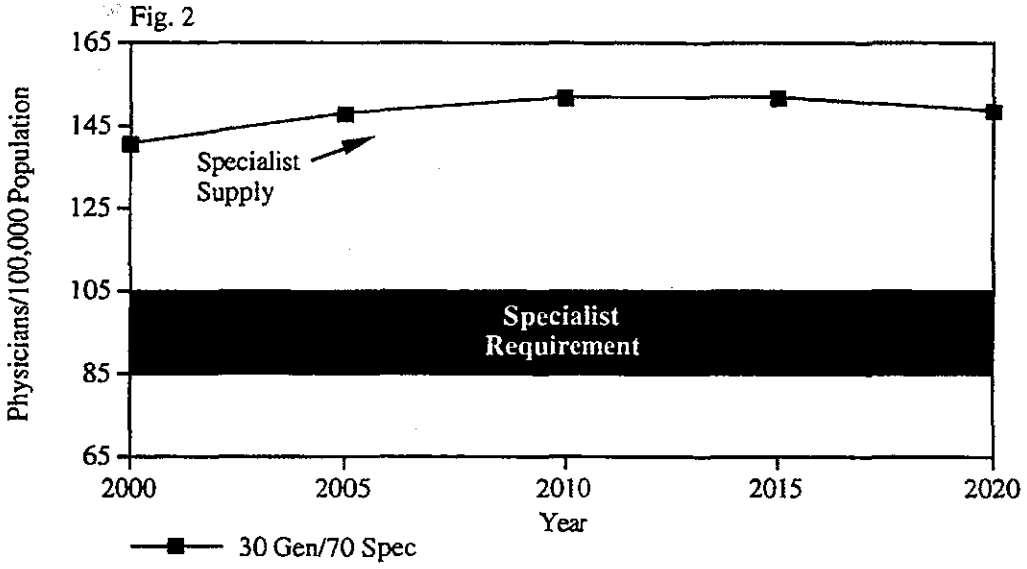


Source: 1965-1992 data AMA Physician Masterfile; AOA, Biographical Records - unpublished data

The growth in physician supply will need to be slowed if cost containment goals are to be achieved and before large numbers of physicians are left under- or unemployed. If current trends continue, COGME projects a year 2000 surplus of 125,000 specialists and a modest shortage of 20,000 generalist physicians in an increasingly managed care dominated system. Figure 2 demonstrates how maintaining the current level of resident training will not bring the specialist supply into equilibrium with managed care staffing patterns. If the current number of residents continues to begin training each year and 70 percent of graduates continue to select specialty careers, the projected ratio of specialist physicians to the population will significantly exceed projected staffing needs through 2020.

IF CURRENT TRENDS CONTINUE, COGME PROJECTS A SUSTAINED SURPLUS OF SPECIALISTS RELATIVE TO POPULATION NEEDS THROUGH AT LEAST THE YEAR 2020

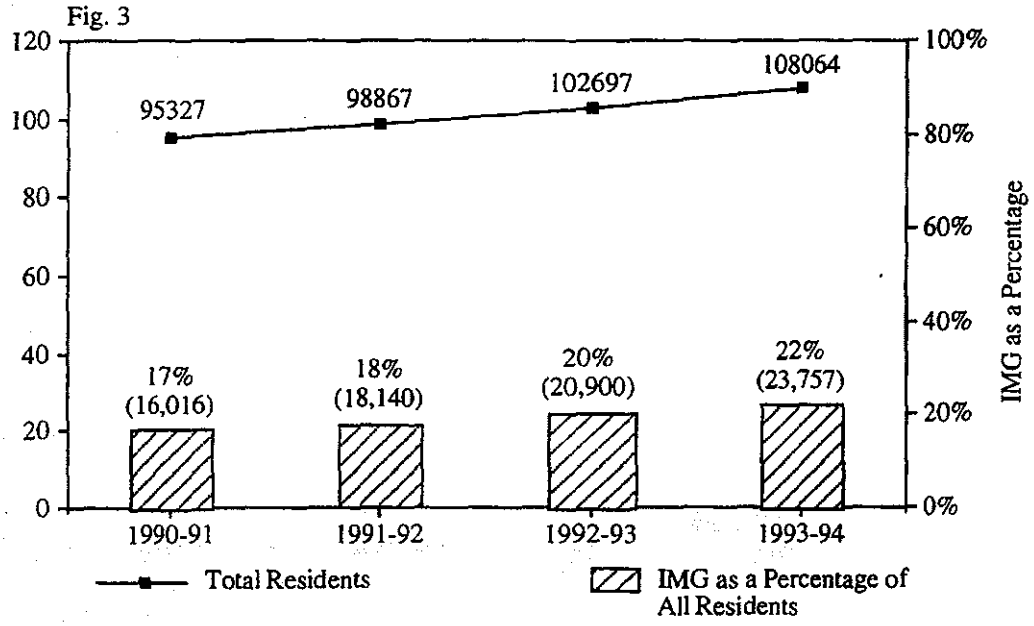
Fig. 2



The number of residents has been growing at approximately four percent per year. Figure 3 shows that this growth has mainly come from the recruitment of international medical graduates. The powerful financial incentives in Medicare's payments for GME may have contributed to this growth.

International Medical Graduates (IMGs) are increasing as a Percentage of all Residents

Fig. 3

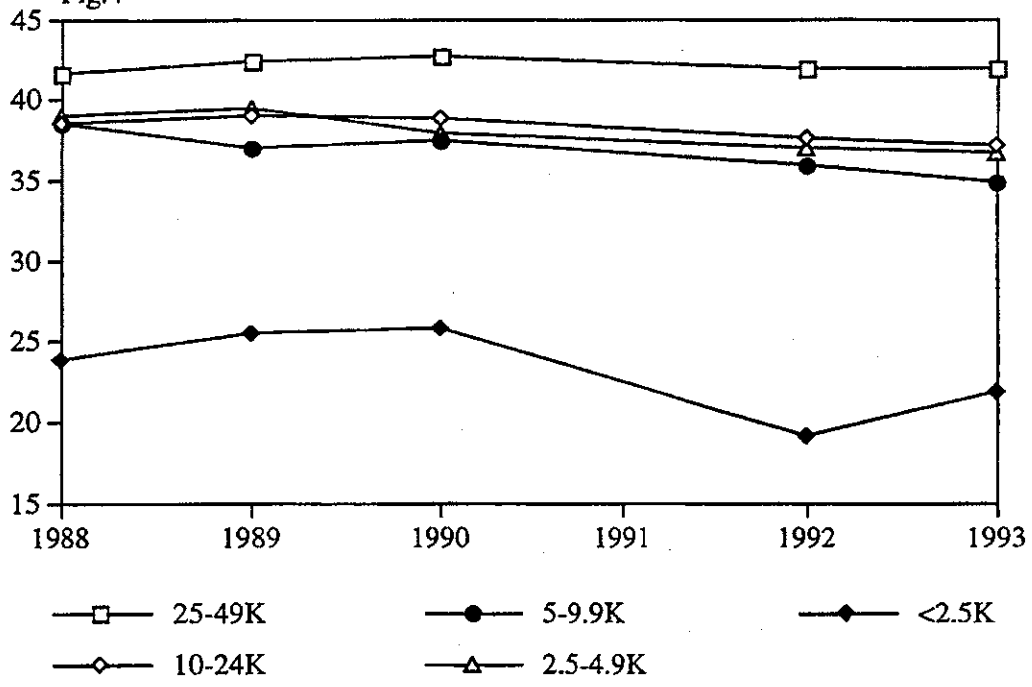


Source: AAMC, SAIMS (Database 1994, plus unpublished updated material, AOA, Biographical Records - unpublished data)

Unfortunately, at the same time that specialist supply is exceeding demand, rural and inner city communities are facing worsening generalist physician shortages. The generalist physician-to-population ratios in counties of fewer than 50,000 residents are substantially lower than in the more populous counties. As shown in Figure 4, these ratios have actually decreased since 1990. These declines in rural counties indicate a special need for family physicians.

THE RATIO OF GENERALIST PHYSICIANS TO POPULATION IN COUNTIES UNDER 50,000 HAS BEEN DECLINING SINCE 1990

Fig.4



Source: AMA Master File

Furthermore, the physician workforce could be more representative of the general population's composition. Although minority Americans will compose almost one-fourth of the population by the year 2000, they represent only 12 percent of entering medical students, seven percent of practicing physicians and three percent of faculty.

Finally, the physician workforce could be better prepared in the key practice competencies needed to provide quality care in the evolving health care system. Surveys of HMO medical directors, and of graduating medical students and residents, indicate inadequate training in such key areas as prevention, cost-effective practice and patient-education, and in community-based and managed care settings.

Therefore, in targeting federal funding for medical education, COGME suggests that the nation should attain the following goals:

1. Decrease the number of specialists trained.
2. Modestly increase the number of generalist physicians trained and improve the quality of primary care teaching.
3. Increase minority representation in medicine.
4. Improve physician geographic distribution.
5. Train more physicians in ambulatory and managed care settings.

In making its recommendations to Congress and the DHHS Secretary, COGME identifies the following principles:

1. Target medical education funding to physician workforce needs.
2. Provide options for budgetary savings that promote physician workforce goals.
3. Simplify and consolidate DHHS medical education financing and minimize regulation and micromanagement.
4. Provide incentives to expand education in primary care, ambulatory, and managed care settings.
5. Assist academic medical centers and teaching hospitals during the difficult transition.

Based upon these goals and principles, COGME summarizes below the relevant DHHS authorities within HCFA and PHS and proposes a consolidated, coordinated, and targeted set of legislative recommendations.

MEDICARE GRADUATE MEDICAL EDUCATION PAYMENT POLICY

CURRENT LAW - FEE-FOR-SERVICE PAYMENTS

Under current law, Medicare pays hospitals for graduate medical education through two different mechanisms.

Direct GME Costs: Under section 1886(h), Medicare payment for the costs of approved medical residency training programs in medicine, osteopathy, and podiatry are based on a hospital-specific per resident amount (PRA). The PRA is based on a hospital's allowable costs incurred in a base period and updated by changes in the Consumer Price Index-Urban. OBRA 1993 eliminated the inflation update during FY 1994 and 1995 for other than primary care residents and residents in OB-Gyn programs. Section 1886(h)(4)(E) limits GME payments in outpatient settings to instances where the hospital bears the costs of that training program. Residents that are beyond the initial residency period are counted as .5 FTE.

Indirect Costs (IME): An explicit payment for increased hospital operating costs in institutions with graduate medical education is made as an add-on to the prospective payment rate for inpatient hospital services. Payments increase by approximately 7.7 percent for each additional 0.1 increase in the ratio of interns and residents per bed. However, this is higher than the analytic estimates of the actual effect of teaching on inpatient costs per case. All residents working in the acute care hospital (including the outpatient department and some hospital-sponsored ambulatory sites) are counted. Time spent outside the acute care hospital, such as in managed care settings and community health centers, is not counted.

CURRENT LAW - RISK CONTRACT PAYMENTS

Medicare's payment to HMOs is based on the Adjusted Average Per Capita Cost (AAPCC) for Medicare beneficiaries in the fee-for-service sector. The AAPCC includes the additional payments made for both indirect and direct graduate medical education under the Medicare prospective payment system for non-HMO beneficiaries in the geographic region. The HMOs negotiate the prices paid to hospitals for services furnished to their enrollees.

MEDICARE PAYMENTS FOR GME

The following are the estimated Medicare direct and indirect graduate medical education expenditures for 1990-1995:

Medicare Direct and Indirect GME Payments 1990-1995 (millions, estimated)

Type of Payment	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995
Direct GME	$ 1,333	$1,420	$1,555	$1,699	$1,769	$1,837
Indirect GME	$ 2,939	$3,208	$3,582	$3,775	$4,123	$4,537
Total GME	$ 4,272	$4,628	$5,137	$5,444	$5,891	$6,374

Source: Estimates by the Health Care Financing Administration as of January 1995

Medicare GME payment amounts in the table do **not** include the amounts for GME implicit in the AAPCC payments to risk-based HMOs, which have been estimated at about $400 million for FY 1995.[1]

[1] Statement by Ms. Barbara Wynn, Health Care Financing Administration, at the COGME meeting of April 27, 1995.

Consequences of GME Policy

There are a number of unintended consequences with current Medicare GME policy:

1. Although consensus is widespread that our nation faces a growing physician surplus, Medicare pays hospitals an average of $70,000 per resident per year for any US or foreign-trained resident they are able to recruit whether or not that resident will be needed in the health care marketplace upon completion of training.
2. Although consensus is widespread that the nation faces a growing budget deficit, current Medicare GME policy provides significant incentives for teaching institutions to increase the supply of residents in training and thus increase Medicare GME outlays.
3. Although consensus is widespread that new physicians should be trained in ambulatory, community and managed care settings to better care for Medicare beneficiaries and the public, both DME and IME payments are based on the number of residents in hospital-based settings. As a result, there is a powerful disincentive to train residents in these essential non-hospital settings. In addition, current AAPCC policy provides disincentives for training in managed care settings.

COGME recognizes the need to analyze government programs to ensure that program objectives are being met cost-effectively. COGME also recognizes that Congress is considering reductions in Medicare programs to ensure its long-term solvency. In Medicare, it is possible to achieve Medicare savings by simply reducing Medicare expenditures for GME without giving attention to needs for workforce policy changes. However, it is also possible to reduce Medicare expenditures while achieving policy goals. This would be a preferable approach, since COGME believes that current Medicare incentives are operating counter to critical public needs for a better prepared physician workforce.

COGME Recommendations on Medicare Graduate Medical Education Funding

Based on the above goals and principles, COGME proposes a consolidated, coordinated and targeted set of legislative recommendations for relevant DHHS programs within HCFA and PHS. These recommendations emphasize the responsibility of the DHHS to use allocated funds wisely as a prudent buyer and to maximize taxpayer investment in physician training.

1. **Continue to pay Medicare GME providers DME and IME for all residents who are graduates of US medical schools, but gradually reduce DME and IME for international medical graduate residents to 25 percent of the 1995 levels. (Budget savings for 1996: $66 million in DME, $170 million in IME.**

   Savings for 1996 - 2000: $1.07 billion in DME, $3.09 billion in IME.)[2]

COGME believes that Medicare should limit both direct and indirect GME in ways that encourage a reduction in the numbers of physicians entering the workforce in the future. Support should be guaranteed to each graduate of a US medical school, but should gradually be reduced for graduates of foreign schools. There are three reasons for this policy. First, the rapid growth in the physician supply in recent years is primarily due to increased numbers of international medical graduates (IMGs), while the output of U.S. schools has been relatively constant. Second, projections of physician need in the United States suggest that there will not be work for these additional physicians. Third, expenditure of U.S. tax dollars to train non-U.S. citizens who will not be needed in this country is a poor use of limited Medicare dollars (Medicare IME and DME payments average $70,000 per resident each year).

Congress is considering options to reduce GME payments. The Prospective Payment Assessment Commission (ProPAC) has recommended reduction of the Medicare Indirect Medical Education (IME) adjustment by approximately $500 million in FY 1996 by reducing the IME factor from 7.7 percent per 0.1 intern/resident per bed (IRB) to 6.6 percent. ProPAC further recommended that the percentage ultimately be reduced to its analytically justified level of 4.4 percent, which at today's expenditure levels would generate approximately a $1.5 billion reduction in IME in FY 1996.[3] The Congressional Budget Office's analysis of Medicare's IME payments discussed rates of six and three percent, which would save $930 million and $2.6 billion, respectively, in FY 1996.[4]

Simple reductions in the IME adjustment to its analytically justified level would generate significant budget savings. However, this approach has some limitations. First, it provides no effective cap on total IME payments. The budget calculations do not take into account the possibility that teaching institutions may respond by increasing the number of residents recruited and offset part of the savings. Residents are cheap and highly qualified labor for hospitals. Furthermore, the number of IMG applicants and entrants has dramatically increased in the past few years.

[2] Medicare budget estimates were provided by Gerard F. Anderson, Ph.D., under contract to the Bureau of Health Professions, based on beginning effective FY 1996. These estimates assume the reduction in the number of IMG first-year residents to take effect in FY 1996 and to roll forward in succeeding years.

[3] Estimate of $500 million reduction per percentage-point decrease provided by Dr. Stuart Altman, Chairperson, ProPAC, in testimony before theCommittee on Ways and Means Health Subcommittee, March 23, 1995.

[4] Congressional Budget Office: Reducing the Deficit: Spending and Revenue Options. Report to the Senate and House Committees on the Budget, CBO, February 1995.

If the goal is to achieve budget savings, then other policies could be implemented that both attain this goal and produce a physician workforce which is better matched with health care needs (see recommendation number two).

The purpose of COGME's policy recommendation is to provide Congress with an option that generates budget savings while effectively reducing the total number of Medicare-funded residents in training. This is a prudent policy since COGME projects a year 2000 specialty physician surplus of about 125,000 patient care physicians in a managed care dominated health care system given present trends in resident production.

In 1993-94, there were 84,307 USMGs in graduate medical education and 23,757 IMG residents. COGME has repeatedly supported a policy recommendation that the total number of Medicare-funded first year residents would be reduced from 140% to 110% of US medical school graduates. Medicare has a legitimate role in supporting some proportion of IMG residents, reflecting their contribution to the care of Medicare beneficiaries. We recommend that the payments for IMG residents be gradually reduced to about 25% of 1994 levels, to effect a reduction in first year IMG residents from 140% to 110% of US medical graduates.

The reduction in numbers of IMGs supported by Medicare could be accomplished by two methods: 1) reducing the numbers of individuals that Medicare will pay for to 25% either by a selection process or by lottery; or 2) reducing payments to institutions to 25% of what they had previously received for IMG residents.

The first alternative would require the development of a selection process or lottery, perhaps through the Educational Commision for Foreign Medical Graduates (ECFMG) or some other sponsor, to certify the individuals who would be funded by Medicare for residency training. The number would be reduced to 25% of current first year IMG residents. Presumably, a selection process would identify the most qualified individuals, but it is not clear how this could be done. A lottery would be simpler, but would be blind to quality.

Alternatively, current DME and IME support could be gradually reduced for each teaching institution to 25% of payments for IMG residents. The mechanism could be to pay at the reduced level of 25% beginning with each successive first-year resident class. This would gradually reduce payments to the 25% level over three to five years. Such an approach would not require the development of an allocation system, but leaves in place payments for an institution's historical numbers of IMG residents.

It should be noted that neither alternative prevents teaching institutions from hiring additional IMG residents with nonMedicare funds. We believe, given the magnitude of Medicare dollars in graduate medical education, the recommended reductions will encourage those institutions with large numbers of IMG residents to reduce the number of residents, although the extent of the effect cannot be predicted. Transition strategies are suggested below for those essential institutions for whom this might cause Medicare beneficiary access issues.

2. Provide incentives for generalist training and increased teaching in non-hospital settings. (Estimated budget savings for 1996: $37 million DME, $452 million IME; Savings for 1996-2000: $263 million DME, $4.14 billion IME.[5])

a. DME and IME payments would be made for physician resident time spent in all nonhospital settings, to remove the disincentive to conduct educational programs in such key nonhospital settings as physician offices, group practices, community health centers, and managed care facilities. Funding would follow the resident to his or her site of training.

b. DME and IME payments for generalist residents in their first three years would be upweighted to 125%, to enhance primary care teaching capacity. DME and IME would be downweighted to 75% for nongeneralist positions for the lesser of five years or the training required for initial board certification.

c. All positions after the lesser of five years or the training required for initial board certification would be weighted at 50% for both DME and IME (see table for definitions and percent payments).

d. IME calculations would not be allowed to increase if the hospital's inpatient bed capacity decreases.

Estimated budget savings for the combination of Recommendations Nos. 1 and 2:

1996: $92 million in DME, $510 million in IME.

1996-2000: $1.20 billion in DME, $6.13 billion in IME.

These recommendations reverse the current disincentives in Medicare GME policy towards primary, ambulatory and managed care education and produce incentives to train physicians in the appropriate specialties and settings to meet Medicare beneficiary and public needs. Despite the acknowledged need to train fewer numbers of specialist physicians and to move training out of the hospital, a recent GAO study estimated that 75% of Medicare GME payments go to specialty training. The rapid growth and popularity in managed health care and Congressional interest in increasing Medicare and Medicaid managed care enrollment makes it essential that more generalist physicians be trained in community-based, managed care settings. COGME recommends upweighting both DME and IME because the significantly larger payments made under IME will provide greater incentives to change the specialty mix. This payment policy can initially be implemented in a budget neutral fashion.

Downweighting IME payments to 50% for residents beyond the lesser of five years or the time required for initial board certification would provide an important disincentive toward specialty or subspecialty training. Furthermore, it would generate significant budgetary savings. The final recommendation is to ensure that the IME adjustment formula

[5] Estimate by Gerard F. Anderson, Ph.D. Savings under Recommendations 1 and 2 are not additive.

not inadvertently increase as a result of the continued market-driven trend towards hospital downsizing.

The following presents COGME's definitions for generalist training and recommended weighting factors for Medicare direct and indirect graduate medical education funding:

Resident Category	Direct Medical Education	Indirect Medical Education
Generalist Training*	1.25	1.25
Non-Generalist training to lesser of first board or 5 years	0.75	0.75
Non-Generalist training past lesser of first board or 5 years	0.5	0.5

**Generalist training should include:*
- *Residents in family practice, general internal medicine, general pediatrics, medicine-pediatric and preventive medicine training*
- *Generalist graduates who take additional geriatrics or faculty development fellowship*

3. Establish a transition program to assist institutions providing essential services which are dependent on IMG residents.

COGME recognizes that IMG residents are not distributed equally across states or types of training programs, and that national goals achieved through Recommendation 1 could threaten service provision in certain areas and institutions. COGME is particularly concerned about large public hospitals and academic centers in metropolitan areas. We recommend that a transition strategy be developed for these institutions. One component could be an expanded National Health Service Corps loan repayment program to provide physician replacements for the IMG residents eliminated in selected institutions. Another could involve start-up funds to train physician assistants and nurse practitioners specifically as resident replacements in highly impacted areas. Another possibility, designed for the substantial number of institutions with small numbers of primarily IMG residents, is to award transition support for institutions who agree to cease residency training entirely.

We recognize that such transition efforts will add to budget outlays, and that they may not be able to be made from Medicare Trust Funds. But they allow a gradual and appropriate transition to lower support, and the net savings across all expenditures would still be substantial.

4. Identify and remove the DME and IME components of the Average Adjusted PerCapita Cost (AAPCC) from Medicare capitation rates and utilize these funds specifically for GME purposes.

Medicare payment policy for risk HMO contractors is carried out through the AAPCC mechanism. AAPCC payments include an estimated $400 million that is based on DME and IME payments, but which are not identified in the AAPCC and which vary according to geographic region. As a result, Medicare GME funds are spread among all risk HMO contractors without being focused on those which actually have teaching programs, or necessarily utilize teaching hospitals for services.

These amounts should be removed from the AAPCC and made available for GME in a wide variety of teaching settings, including teaching hospitals, managed care organiza-

tions with teaching programs, etc. This would help rectify a possible inequity to teaching hospitals that provide care to Medicare beneficiaries enrolled in risk contract HMOs but currently do not receive Medicare GME on their behalf. It would also eliminate the current disincentives to HMOs who wish to establish or expand residency training activities but do not currently receive explicit reimbursement for their efforts.

5. Create demonstration projects to foster the growth of consortia to manage medical education policy and financing.

As health care increasingly becomes dominated by integrated managed health care systems, graduate training opportunities will change dramatically. COGME believes that both the accrediting bodies and HCFA should encourage the development of arrangements that will undoubtedly provide more diverse and necessary training experiences than currently exist. COGME has previously encouraged the development of medical education consortia or training networks to determine the number and specialty mix of residents, to facilitate the more appropriate utilization of training settings, and to receive and distribute GME funds to whoever bears the training costs, in a manner that simplifies administration and maximizes flexibility in accomplishing physician workforce goals. Demonstration projects could be utilized to develop such a consortium approach to residency training and GME management.

PHYSICIAN EDUCATION PROGRAMS IN THE PUBLIC HEALTH SERVICE

Although spending for medical education by HCFA and PHS differs by orders of magnitude, certain PHS programs (the National Health Service Corps (NHSC) under Title III and Health Professions Education under Title VII) have had a significant impact on the physician workforce. For example, targeted Title VII funding has contributed to a 25% growth since 1980 in the number of Departments of Family Medicine and a 40% growth since 1990 in the number of required student clerkships in family medicine. Building such family medicine teaching capacity has been cited by the GAO to be associated with increased student selection of generalist physician careers.[6] Targeted Title VII funding has contributed to a 200% increase in underrepresented minority enrollment in health professions schools. Today, 3.8 million people who would otherwise lack access are receiving quality primary care from 1,900 NHSC professionals.

A significant number of PHS programs provide institutional and individual incentives to attain COGME's national physician workforce goals. Title VII and the NHSC are perhaps the best known PHS programs that support the following COGME goals to enhance:

- generalist physician training
- minority recruitment
- geographic distribution
- primary care faculty development
- quality of practice

CURRENT LAW

Title VII of the Public Health Service Act contains 40 authorities or program cycles supporting health professions capacity development. Overall, Title VII provides an estimated $207 million in primary care medical education, multidisciplinary training, minority/disadvantaged training, and student assistance related funding (see table). Each of these programs has its own special eligibility and project requirements. Within Title VII, 25 different authorities address aspects of COGME's physician workforce goals. Title VII programs are implemented by the Bureau of Health Professions, of the Health Resources and Services Administration (HRSA).

Another HRSA program, the NHSC, supplies primary health care providers for health professions shortage areas. Through service-obligated and volunteer programs, the NHSC recruits, trains, and places primary care providers in Community and Migrant Health Centers, health care to the homeless programs, federally qualified health centers, health departments, and free-standing private practices that are tied into a health care system.[7] In 1995, the NHSC has a budget of $45 million and a "field" strength of 1,987 health care practitioners. Eighty million dollars were appropriated in 1995 for scholarships and loans which provide incentives for physicians to practice in underserved inner city and rural areas.

Primary care research funding is supported in the Agency for Health Care Policy and Research (AHCPR). In 1995, AHCPR's budget was approximately $157 million. Major budget areas include: (1) research on

[6] General Accounting Office: Medical Education: Curriculum and Financing Strategies Need to Encourage Primary Care Training. GAO. Report HEHS-95-9. Washington, D.C., 1994.

health care costs, quality and access, (2) the National Medical Expenditure Survey (NMES), and (3) medical treatment effectiveness studies. Two percent of the NIH's National Research Service Award's (NRSA) funding is administered by HRSA (1%) and AHCPR (1%) to train primary care researchers.

Physician Education/Primary Care Research Appropriations History (Selected Title III, VII & IX PHS Programs)

Program	Appropriations History (in millions) FY 1993	FY 1994	FY 1995
Primary Care Programs[1]			
Family Medicine Departments & Training	$38.2	$47.2	$47.2
General Internal Medicine/Pediatrics	16.8	16.8	16.7
Physician Assistant Training	4.9	6.6	6.6
Multidisciplinary Training Programs[1]			
Area Health Education Centers	19.8	22.2	24.6
Geriatric Education Centers	10.0	9.2	9.1
Health Education and Training Centers	2.8	2.8	3.7
Rural Health Interdisciplinary Training	4.0	4.0	4.0
Minority/Disadvantaged Health Professions Programs[1]			
Centers of Excellence	23.5	23.5	23.5
Health Careers Opportunity Program	25.0	25.0	26.3
Loans Repayment/Fellowships - Faculty	1.1	1.1	1.0
Student Assistance Programs[1]			
Exceptional Financial Need Scholarships	10.4	10.4	11.1
Financial Assistance for Disadvantaged HP Students	6.2	6.2	6.6
Loans for Disadvantaged Students	7.9	7.9	8.5
Scholarships for Disadvantaged Students	17.1	17.1	18.3
National Research Service Awards			
Bureau of Health Professions	2.6[2]	3.7[2]	3.8[2]
National Health Service Corps Field Program	42.0	44.7	45.0
National Health Service Corps Recruitment Program	73.4	79.3	80.1
Agency for Health Care Policy & Research	122.3	148.6	156.8
TOTAL PHS (Selected Programs)	**$428.0**	**$476.3**	**$492.9**

[1]Title VII PHS Programs
[2]FY 93 & 94 represents actual disbursements. FY 95 represents estimated disbursement.

COGME Recommendations on PHS Programs

1. **Reauthorize, at 1995 pre-recision appropriated levels, the National Health Service Corps, Title VII (Health Professions Education), and primary care research (estimated budget impact: current appropriation level of approximately $493 million).**

Under the Public Health Service Act, Title VII programs, the National Health Service Corps, and primary care research support through the National Research Service Awards (NRSAs) and AHCPR have been critical in achieving COGME's goals of increasing generalist physicians and physician assistants, improving primary care teaching capacity, increasing minority representation, and reducing geographic maldistribution. Current levels of funding for the above programs need to be continued, at least for the next five years until State and market mechanisms have the possibility of replacing all or part of these incentives.

2. **Consolidate Title VII programs and include the National Health Service Corps as recommended in the President's fiscal year 1996 Budget Proposals and the Health Professions Education Consolidation and Reauthorization Act of 1995 (S. 555).**

Consolidation of Title VII programs will allow simplification and flexibility of program administration. It will assist in focusing scarce Federal resources on activities that have a demonstrable impact on the production of primary medical care providers and public health workers. Demand is high for generalist physicians and major shortages continue in rural communities and in underserved rural and urban shortage areas.

In addition to simplifying administration, consolidation of the primary care training grants will provide opportunities for more cooperative development of education programs within these disciplines as well as continuation of specialty specific programs. The Area Health Education Center Program would focus on providing community-based education in the health professions and retaining health professionals in rural communities and in underserved urban and rural areas. Multiple existing minority and disadvantaged authorities would be consolidated into a new authority that would encourage competition for awards to design or implement cooperative arrangements and to provide for creative demonstrations or strategic workforce activities to increase minority representation. Competitive funds would reward institutions which commit to expand much needed generalist teaching capacity and produce practitioners for underserved communities.

COGME recommends the provisions in the President's proposal and S. 555 to include the NHSC in one of the proposed Title VII clusters.

3. **Title VII educational programs which are funded either should have demonstrated effectiveness, or through program design should demonstrate a high likelihood of achieving specified outcomes. Priority should be given to those primary care training programs which place a high percentage of**

graduates in primary care practice, in rural areas, and in underserved urban and rural areas.

Specific national goals for Title VII programs, common outcome measures and reporting requirements are essential to the effectiveness and success of these programs in attaining workforce goals. This strategy focuses Federal support upon training activities of known effectiveness in producing needed health care workers and in improving geographic distribution and minority representation.

4. **Reauthorize the Council on Graduate Medical Education (COGME) as recommended in the President's fiscal year 1996 Budget Proposal and the Health Professions Education Consolidation and Reauthorization Act of 1995 (S. 555).**

COGME has played a significant role in emerging physician workforce issues and identifying critical elements in the changing health care system. COGME is currently developing key health policy recommendations to Congress, the Secretary, Department of Health and Human Services, and other important policymakers on generalist and specialist physician supply and requirements, women and medicine, the impact of managed care on the physician workforce and medical education, minorities in medicine, the geographic distribution of physicians in rural and inner city communities, and DHHS financing policies for medical education.