



*Advising the Congress on Medicare issues*

# Aligning medical education with health system needs

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# Session overview

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- Background information on questions raised in last meeting
  - Title VII, VIII, National Health Service Corps
  - Medicare's residency caps and residency growth
- Goals of medical education and training
- Problems previously discussed with current medical education financing
- Opportunities for addressing some of the problems

# Selected HRSA programs: focus on primary care, diversity, and distribution

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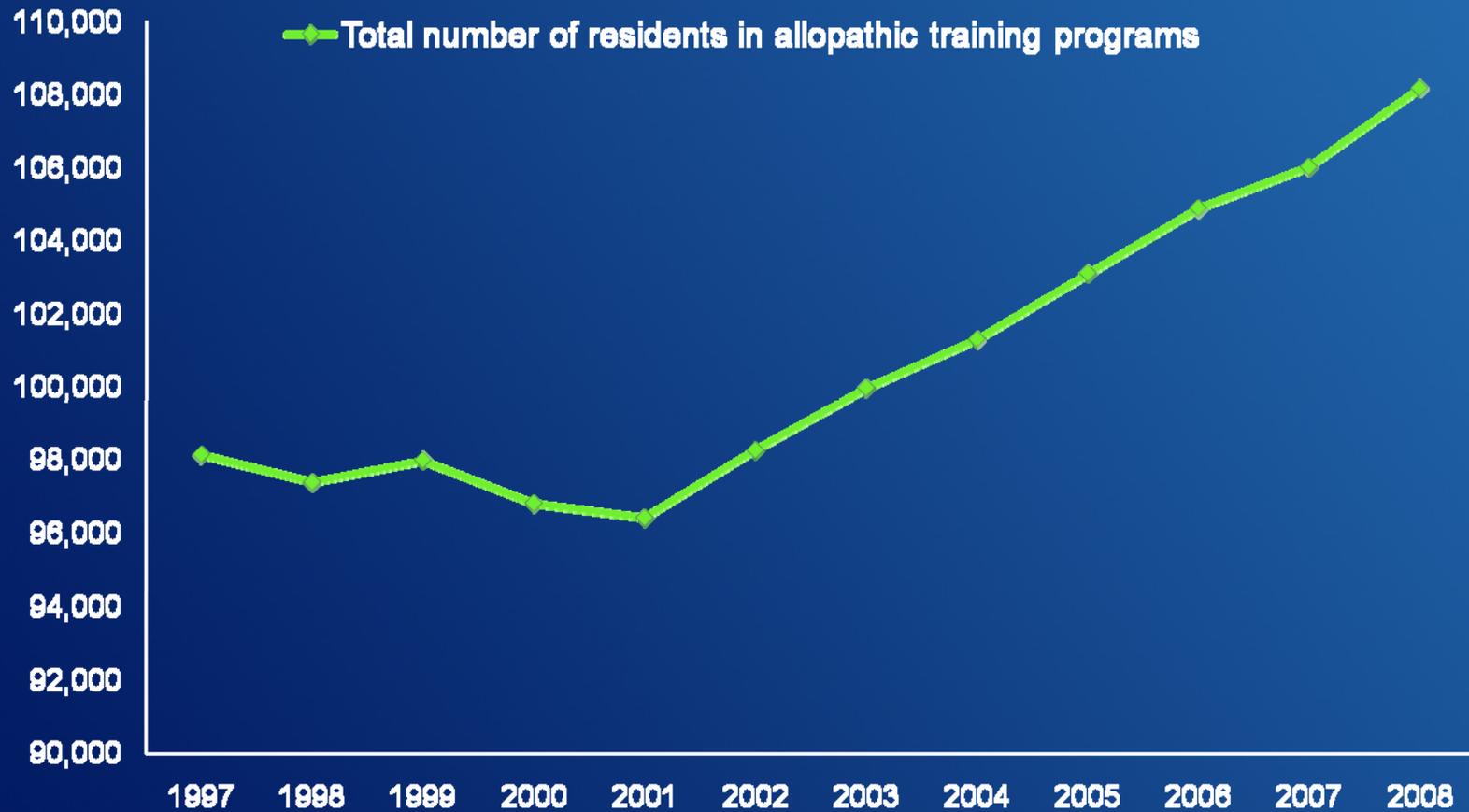
- **Title VII** – Primary care training grants to medical schools and residency programs
  - **Title VIII** – Nursing workforce development grants
  - **National Health Service Corps** – Loan forgiveness and scholarship programs for physicians, advanced-practice nurses, and other professionals who practice primary care in underserved communities
- Programs are subject to reauthorization and annual appropriation

# Counting residents

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- Weighted resident count for direct GME payments
  - Full-time resident in first residency counted as 1.0 FTE
  - Second residency counted as 0.5 FTEs
  - Residents are not weighted for IME
- Count used for payment capped at 1996 levels
  - Exceptions made for certain programs
  - MMA provided for some redistribution of unused slots
  - Reform proposals considering additional redistribution
- In 2006, hospitals supported about 8,000 FTE residents over Medicare's cap
  - No direct or indirect GME payments
  - Hospitals over cap have lower share primary care residents
  - Will be updating analysis through 2008

# Total number of residents in training has grown annually since 2001

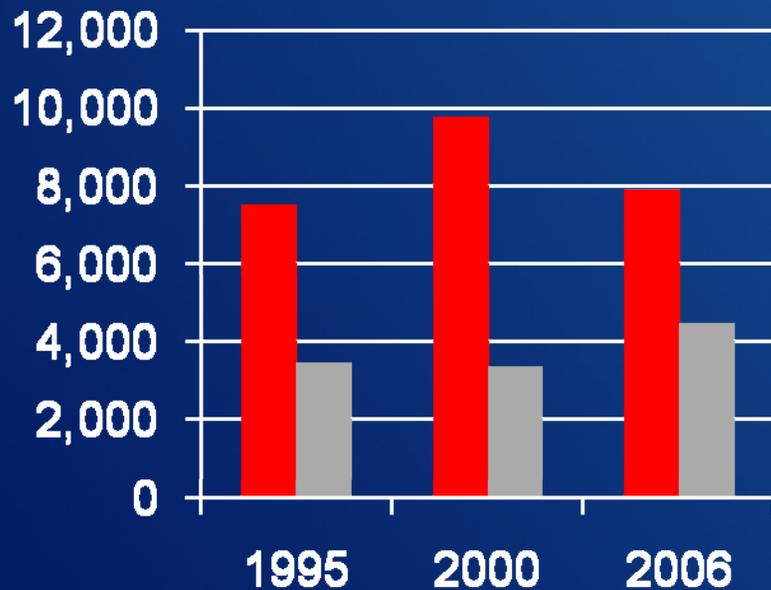


Source: MedPAC analysis of annual medical education issue of JAMA.

# More residents subspecializing and fewer entering generalist careers

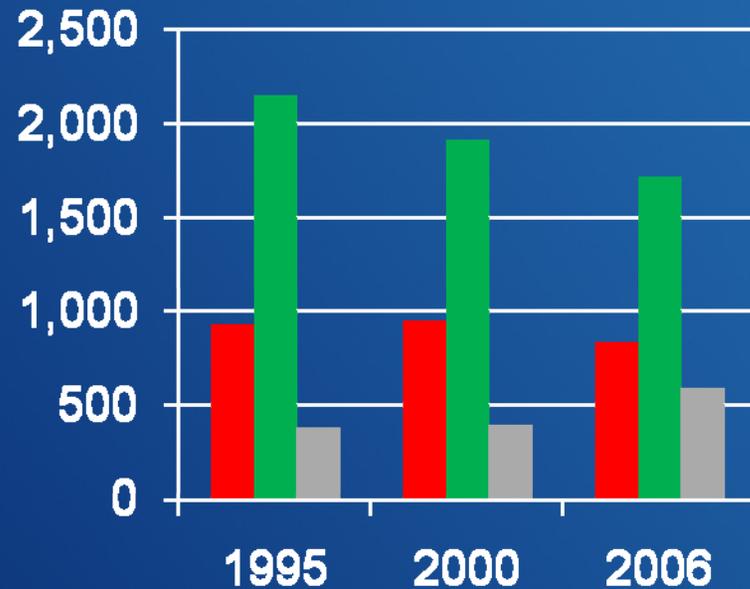
After core training...

## Primary care



■ Enter primary care practice  
■ Start subspecialty program

## Surgery



■ Enter general surgery practice  
■ Enter other type of surgical practice  
■ Start surgical subspecialty program

# Desired goals for medical education and training

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- To ensure that students possess the knowledge, skills, and values necessary to provide high-quality healthcare
- To produce the workforce that best serves the needs of our society
- To become leaders in forming a high-value health system

# Problems with current medical education financing

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- Pipeline issues
- Delivery system reform issues
- Economic inefficiencies

# Problems: pipeline issues

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## Overall problems

- Declining number and share of generalist physicians (primary care, general surgery) entering the workforce
- Under-representation of minorities, rural, low-income students
- Medical school admissions criteria too narrow
- Underuse of mid-level health professionals

## Specific to current Medicare GME/IME

### *Residency focus*

- Too late to affect pipeline demographics
- Little influence on specialty mix and training location
- Limited financing for mid-level professionals

# Problems: delivery system reform issues

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## Overall problems

- Insufficient residency experience in coordinating care across settings
- Limited residency curricula on needed delivery reforms
- Pipeline needs (i.e., generalists, mid-level professionals)

## Specific to current Medicare GME/IME

*Payments tied to inpatient admissions*

- Residency positions can serve hospital staffing purposes
- Mismatched with overall goals to improve ambulatory care and prevent avoidable hospital admissions

# Problems: economic inefficiencies

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## Overall problems

- Government (Medicare, Medicaid, VA, DoD, HRSA, others) funding more than its share of the costs; limited private investment
- Subsidies support hospital staffing choices

## Specific to current Medicare GME/IME

- Approx 1/3 of funding for costs not attributable to residency stipend or higher inpatient care costs (~\$3 billion in 2008)

# Opportunities for addressing some of the problems

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## **Pipeline**

- Outside of Medicare, enhance funding for other federal programs (Title VII, VIII, National Health Service Corps)
- Direct a portion of funding to residency programs

## **Delivery system reform**

- Provide incentives for improved training environments (e.g., full-functioning ACOs)

## **Economic inefficiencies**

- Reallocate Medicare subsidy that is not attributable to residency stipend or higher patient care costs

# Opportunities for addressing some of the problems

