MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 24, 2003
9:40 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Impact of the GME resident cap on geriatricians
-- Marian Lowe, Craig Lisk

MS. LOWE: Without Craig, I'm here to talk to you today about resident caps and the training of geriatricians. This report is required by language included in MedPAC's 2001 appropriations. It did not include a due date.

So what I want to talk to you talking, the appropriations language raised several concerns about whether we have an adequate supply of geriatricians, the needs of an aging and growing population of Medicare beneficiaries, and specifically they were interested in the impact of the hospital specific cap on residents and the effect that that had on the supply of geriatricians.

What I'm going to do here today is try and get to what the report requested, examining the effect of the resident caps and looking at whether or how to alter the cap.

What I want to do here right now is walk you through the evidence that we looked at and the conclusions that we came to. And then if you're comfortable with that, with a little bit of polishing, we can forward this on to Congress. If you want to have some more discussion of this, we can bring this back at our next public meeting in September.

First, a little bit about geriatricians. They are experts in aging-related issues. Geriatrics is a subspecialty of family practice, internal medicine, and psychiatry. A one year geriatric fellowship is required for certification in geriatrics, following ones initial residency in one of those three areas. This requirement used to be two years for certification. It was reduced to one year in the '90s and I will return to that point in discussing a little bit more the importance of that later in this report.

Generally training for those who are pursuing careers in academia is two or more years. Recertification in geriatricians is required every 10 years, and they must maintain their certification in their underlying area of family practice, internal medicine or psychiatry.

Just to point out that many medical schools and residency programs offer elective courses and rotations in geriatrics.

First to give you a sense of since Congress asked us to look at the resident caps, we wanted to give your a sense of what it means to a hospital to have an traditional resident on the direct side. This gives me an opportunity to first point out two places in existing policies that already provide special treatment to geriatricians. When we see this resident weighting factor, although geriatrics is a subspecialty, geriatric residents are counted as one FTE in this weighted factor, instead of .5 as other subspecialties in their first year of training.

Also, when the per resident payment amounts were frozen in the mid-'90s for specialists, geriatrics was exempted from that freeze. So their per resident payment amounts are about 6

percent higher.

So in this example, you've got a first-year geriatric fellow with a per resident payment amount of $70,000. And given that Medicare's share of the total days, the direct GME that that hospital is getting is about $24,000.

Now over on the IME side, since we spent a lot of time earlier this year discussing IME, I'm not going to spend too much time here. But basically, as you know, the higher a hospital's resident-to-bed ratio, the higher the adjustment to their payments. And in this example of a 400-bed hospital that's training 100 residents, that adjustment to their payments, given their wage index and case-mix index of one and 2.0 respectively, they're getting about $71,000 in additional payments each year. Combined, the direct and indirect medical education payments for that resident is about $95,000 for the hospital. So as you can see, it's not an insignificant amount of money we talk about when you add an additional resident.

Next, the recent changes in Medicare's GME policies. The Balanced Budget Act placed a cap on the number of residents a hospital could train. And that cap is based on 1996 resident accounts.

I do want to mention that when the caps were put in place, that system, although GME pays for dental and podiatry residents, they were not included in the calculation of the cap.

Basically, what was going on there was that there was a strong financial incentive, as you saw from the last example, to continue to increase the number of residents a hospital is training. The caps were imposed to kind of delink that incentive to train more residents with the financial incentive.

Again, I just want to remind you the two situations I pointed out earlier, the special treatment for geriatricians, the exclusion from the freeze in the per resident payment amounts, and the fact that they're not counted as subspecialists for calculation of that direct GME payment amount.

So next, a little bit about what we know about the geriatricians in training. These are the total number of training positions offered and filled, the offered line being the higher of the two, from 1996 to 2002 based on AMA data. What this chart shows is some pretty steady growth in the number of slots up until 2000 and then a decline. The number of positions filled also grows, but it fell in 2000 when the number of residency positions available actually reached an all-time high. Since then that number of positions filled has recovered to about its 1999 levels.

When we break this up by first and second year physicians, the first year being what's required for certifications, you can see -- I'll show you how these numbers reflect changes in the training criteria, and possibly a general decline in interest in primary care. And just to the point out that these numbers are pre- and post-implementation of the resident cap. What they do kind of show you here is that there have been consistently more positions offered than those that are filled.

Next, we look just at the first-year positions. And what you can see here is steady growth in the number of first year

positions. And as you can also see, the fill rate has fallen significantly since 1999, to about 69 percent. Although after a brief dip there in 2005, the number of residents is now at an all-time high in those first-year training positions.

The growth in the new positions comes from basically two sources that I want to point you two. first, from 1999 to 2002, 13 new training programs in family medicine and internal medicine have been added. Seven other additional programs were added in psychiatry. This inevitably will affect the geographic availability of positions.

But perhaps more substantial is the result of hospitals converting second-year training positions to first-year training positions following a decision of the certification board to reduce the requirement to one year for certification. Now this did have the intended effect of increasing the number of positions available, but when I turn over to the second-year training positions, you can see that they have taken a significant dip in the number of positions available to actually less than 100 now. Of course, interest, as you can see by the number of positions that are being filled, has been relatively flat. But I just want to point out, too, that this second-year and more training positions is what we would consider the pipeline for those pursing careers in academia, the educators of future geriatricians and providers of geriatric education to all medical residents.

Again, we think a lot of this is caused by substitution of second-year positions in first-year positions.

So quickly let me talk about need and availability. As you can see, the estimates on the range of what we need for clinicians is very broad. This really depends on the model that we used to determine what we need for geriatrics, whether or not we are assuming that at the low-end here the assumption is that primary care providers are providing the bulk of the care, versus the other high end of the model which is assuming the geriatricians are far more involved in the actual clinical care. The range for academics in much smaller, as you can see. And again, these are the estimated need for academics for both geriatric residency programs and all medical residents.

So then we turn to what we know about the current position. We have about 9,000 people who have been certified as geriatricians. As you can see, that's kind of in the middle of some of these ranges of what we need. But depending on what you believe the model of care is, we could be above or below that need.

What we do know is that the number of certified geriatricians is expected to fall in the short run because there's a very low recertification rate. About 50 percent of people are recertifying. So that's going to cause a dip in the number because there's a far larger number of people who would need to recertify than there are people who are entering geriatrics as new folks coming out of training programs.

This could mean that there's not a large economic incentive to recertify, but it also doesn't mean that these people are actually leaving the profession. It may be that they're not

recertifying. So we don't want to indicate that these people are dropping out of practice, although some retirements could be the case here since these are folks who have been in the field for 10 years.

DR. NELSON: Just to point out that the recertification rates are comparable to the other subspecialties of internal medicine, but geriatricians don't have the option of only recertifying in their subspecialty. They have to recertify in internal medicine as well.

Still, the process is relatively new. Recertification has only been going on for three years. And whether that will pick up or not if anybody's guess. But it's sort of a unique situation.

And I think that expressing concern that the possibilities of the numbers of certified may fall doesn't necessarily mean that they will not still be qualified geriatricians. They just won't have recertified.

MS. LOWE: And that is the clarification that I was trying to make, very important, that these people may still well be in practice.

Just generally, when we're talking about the supply of specialists, we want to understand that there's many factors in here, the patients demand for service, the expected payment including the patient mix, interest in subspecialty, training by physicians, and also the geographic availability of residency positions. And now I want to talk a little bit more about how some of that may be more specific to geriatricians.

First, I want to point out that both hospitals and physicians are making choices about who to train and what type of training to pursue. Pointing out that under the caps that hospitals are free to distribute residency positions as they see fit. And as you see there, there are a lot of -- and that's just a brief look -- there are a lot of factors that influence what decisions they make about residency positions to offer.

When you think about revenue opportunities, if they're thinking in terms of resident mix, it allows them to bring in a higher volume of the patients or a higher case-mix to add to their bottom line, that could be a very strong incentive. The academic priorities, as Alan alluded to, geriatrics is a relatively new field and some of these institutions will may have very established priorities about their residency programs that would influence the allocation of slots.

And then finally, resident interest -- and this is, I think, especially important for those hospitals that are trying to stay at their cap, in that if interest in a geriatric position is low, they may not want to offer a position that may likely go vacant.

Likewise, the influences on physicians choice of specialty, income potential obviously being a large one, geriatrics is not perceived as a well-paying specialty, given the likely complex and frail patient mix.

Very closely related to that, the perception of the specialty, that they're caring for very complex patients with usually irreversible conditions.

And finally, the influence of faculty role models in

recruiting folks into the profession. It's fairly new and fairly small, and so that effect may be somewhat tempered. And then I'm going to come back in a few minutes and talk more about the income potential and the payment issue for geriatricians.

But first, sticking to this issue of the caps, the conclusion that we're coming to based on the vacancies that are here and the other factors that are involved in these selections is that the caps are not the significant factor limiting the supply of geriatricians.

Secondarily, that lifting the caps is inconsistent with where the Commission has been in previous discussions. As you may recall, we have taken position in the past that policies on the number of distribution and mix of providers should be done through targeted programs.

Just as an aside, I wanted to point out that HRSA, the Health Resources and Services Administration, actually has a geriatric program through their Area Health Education Centers, that supports residents, especially second-year residents, for those training in geriatrics and to the field of academia.

And then secondly, the discussion that we had for our March report, that Medicare is paying more than the empirically justified amount for IME. If we were to lift the caps on geriatrics, what we're essentially doing is upping the amount of money that's running through IME, as well as increasing the direct GME dollars.

The last point here is that looking at caps benefits all geriatric programs equally, regardless of the quality or the practice model that we think is appropriate. You're offering the opportunity to anyone -- and to point out that, as you can see, there's a lot of positions that are vacant and we're not able to quantify the effect of the quality of the program on their ability to recruit residents into those programs. So I wanted to put that out there as one consideration in lifting the caps. It's a very blunt instrument to maybe nudge up the supply just a little bit more.

Now onto the last slide here. When talking about the factors specific to geriatrics, I alluded all through this presentation about physician payment. Providers cite a lack of coverage of some of the core services that geriatricians seek to offer management, geriatric assessments, those sorts of things. And also that the payment rates, being that they are based on delivery of a service to a typical patient, may undervalue the services that geriatrics provide because of the time necessary to care for their patient population.

Next, I want to underscore the decision of the certification board to reduce the requirement for certification fro two years to one year. What this essentially did was provide an incentive for hospitals to increase the number of first positions available, which it did have its intended effect. But what it did was remove the financing available for those second-year positions, which is kind of the supply line for the academic geriatricians. And that certainly has had a telling effect in the numbers of positions available for second-year training.

DR. MILLER: By changing from a two year to a one year,

there was additional Medicare dollars through DME for that second-year of the program. And when they made this change, they essentially walked away from the dollars, which made them less attractive to the hospitals.

MS. LOWE: That was an excellent clarification. Medicare pays the minimum time necessary for certification. When they reduced it to one year, the minimum followed that.

The last piece here, when we talk about what is it we think is the proper role of geriatricians in the health care delivery system? The first piece is how do we want to train our future physicians? Do we want all of them to have more training in geriatrics? Or do we want to produce more people who are trained geriatricians? Or some combination thereof? And that's obviously not within the scope of this report, but certainly a consideration when thinking about what sort of supply we want to produce.

The second thing is the model of care for the elderly, given the ranges of need that you saw earlier, is it appropriate for -- if you're training more physicians in geriatrics for more of the care to be delivered by primary care physicians? Or do you want to steer more of the frail elderly to people who are specifically trained as geriatricians? And those are important decisions for other bodies in the profession to be considering.

So I will stop there and ask you for your responses on the paper and suggestions on the conclusions or any other changes.

MR. SMITH: Marian, I infer from what you said, but wonder if we know that the offered/filled graph would look different for other specialties.

MS. LOWE: The fill rate for geriatrics is lower than a lot of other -- most other subspecialties.

MR. SMITH: So the fill rate is lower?

MS. LOWE: Yes.

MR. SMITH: So the conclusions that suggest that this is related, that there's a big supply side piece of this, seem justified by looking at other fill rates?

MS. LOWE: Yes.

DR. MILLER: I know on a procedure side, on the surgery side, they generally have less problem filling slots. But on the GP/IM side, my sense is that they have the same issue. So I just want to clarify that.

DR. REISCHAUER: I was just wondering, based on what we were asked to do, whether we need an explicit recommendation that this isn't a problem. Or just the tone of the chapter is enough.

MS. LOWE: I think what we wanted to do here is indicate -- the request of the appropriators was tell us how to change the cap. And we certainly don't want to make a recommendation on -- what I think we're saying here is that we don't think the cap should be changed.

I would defer to you and Glenn and the Commission as to whether or not you want to make a recommendation that says do not change the cap, or whether you want to indicate to the Congress that there are a lot of other issues at play here and we think those are the more important ones for you to focus on.

MR. HACKBARTH: That's certainly my feeling. Is there

agreement, consensus, that however worthy the goal of increasing the number of geriatricians or clinicians that have access to some training, however important that might be, the issue here is not the caps? The problem is rooted in other things.

There's agreement on that?

That's the central question that we've been asked by the Appropriations Committee. So was the plan to try to include something in the June report or draft a separate letter of response?

MS. LOWE: The plan is to do this separately and forward it as a separate of response.

MR. HACKBARTH: If that's the case, if there's consensus, what I'd suggest we do is have the staff draft an appropriate letter.

DR. REISCHAUER: But do you attach all this material to it? I mean, it strikes me as a very useful piece of analysis that should be out there for the public.

MS. LOWE: I like to think of this basically as the letter not formatted as such yet.

DR. REISCHAUER: Pretty long letter.

MS. LOWE: Whether at the end of the day this --

MR. HACKBARTH: It's a letter report as opposed to one in a red book or in a white binding.

MS. LOWE: Think of it more like a very thin white report, like we've done in the past.

MR. HACKBARTH: There's precedent for that. We have done letter reports in the past. So it will have an appendix with tables and graphs and what not? Is that what you envision?

MS. LOWE: Yes, the materials that you saw in what we attached will be embedded in the text.

MR. HACKBARTH: Okay. All right. Make it so.

We are done for today. So thank you, Marian.