



TEACHING HOSPITAL

Federal Priorities 2016

GME and New Jersey

New Jersey hospitals and medical schools have long been instrumental in maintaining the state's physician workforce needs, from one of the earliest schools granting medical degrees to the announced opening of a fifth degree-granting institution in 2018. Out of 71 acute-care hospitals, 43 New Jersey hospitals maintain residency programs, a higher proportion than nearly any other state. These programs vary in size and scope and include critical primary care programs as well as training in key specialties and fellowships. More than 3,100 residents are trained in New Jersey's hospitals annually, ranking New Jersey 10th in the nation in resident full-time equivalents.

In addition to their commitment to training the state's future physicians, New Jersey's teaching hospitals and medical schools also conduct groundbreaking medical research and clinical trials for lifesaving drugs and devices while serving a critical role in delivering patient care to the state's neediest patients. In short, the state's medical education community is an indispensable cog in the healthcare delivery continuum and a key asset that must be protected.

Despite these efforts, there are growing fears of a pending shortage of physicians in New Jersey. Trends in physician workforce data support the concept of a statewide deficit in the physician workforce supply pipeline:

- According to the Association of American Medical Colleges (AAMC), 32.7 percent of active physicians in New Jersey are over the age of 60 – the third highest percentage nationally.¹ On the other side of the age spectrum, only 13.3 percent of New Jersey physicians are under 40, the 5th lowest percentage in the nation.

4 Actions to Support the Next Generation of Physicians

1. **SUPPORT H.R. 2124/S. 1148, the Resident Physician Shortage Reduction Act, to increase available Medicare-supported GME positions by 15,000 over five years.**
2. **SUPPORT legislative efforts – including H.R. 1343/S. 688, Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015 to more fairly apply Hospital Readmissions Reduction Program penalties to providers serving the most vulnerable patient populations.**
3. **PRESERVE Medicare support for residency training positions given the uncertainty of New Jersey's physician workforce.**
4. **PRESERVE the 340B Drug Discount Program for New Jersey's safety net hospital providers and the patients they serve.**

- Compared with other Mid-Atlantic states, New Jersey is short on medical students. New Jersey has 24.4 medical students per 100,000 population – 37th nationally. New York has 51.5 medical students per 100,000 population, and Pennsylvania has 63.5.
- New Jersey also lags behind our neighbors in resident physicians per 100,000 population. Among accredited allopathic programs, New Jersey's 32.2 residents per 100,000 population ranks significantly behind New York (81.5) and Pennsylvania (61.6).
- New York and Pennsylvania also rank 1st and 2nd in the nation in total resident physicians with more than 16,000 and nearly 7,000 current residency positions, respectively. New Jersey maintains slightly more than 3,000 residency positions.

FUNDING

Graduate medical education (GME) across the country has primarily been funded by the Medicare program since its inception in 1965. GME funding is divided into two streams: direct and indirect. Direct GME reflects Medicare's share of the direct costs of resident training. Indirect medical education (IME) funding helps compensate for the higher costs associated with teaching hospitals, such as “learning by doing” and the greater use of emerging technology at these facilities. The IME adjustment is a percentage add-on to the DRG rate that varies on the intensity of the hospital's teaching program as measured by the ratio of the hospital's number of residents to its number of beds.

Many states, New Jersey among them, utilize Medicaid pass-through payments to augment federal GME funding. Thankfully, the state budget has recognized the need for additional physician workforce capacity. Since state fiscal year 2008, New Jersey state GME support has grown from \$60 million to \$188 million in 2017. While generous, this funding is significantly lower than the nearly \$2 billion provided to teaching hospitals in New York state. And despite the subsidy increase, New Jersey hospitals are still reimbursed less than half their reported teaching costs by Medicare and Medicaid.

This enhanced Medicaid GME subsidy pool has allowed New Jersey teaching hospitals the flexibility to attract new physicians and add programs in primary care and other specialties to better serve their communities. Since the subsidy expansion was initiated in 2008, more than 500 new resident FTE positions have been created in New Jersey. This expansion has allowed New Jersey's teaching hospitals to create new resident training programs in underserved areas as well as specialties and subspecialties in shortage.

This workforce data underscores the need to ensure a robust physician workforce for New Jersey's patients. While New Jersey's medical schools and teaching hospitals have worked to employ innovative strategies to keep medical students in New Jersey's residency programs, the numbers are not stacked in the state's favor. Quite simply, there are more opportunities for aspiring physicians at out-of-state training sites within the Northeast and Mid-Atlantic.

¹ Association of American Medical Colleges. (2015, November). 2015 State Physician Workforce Data Book. Retrieved from [http://members.aamc.org/eweb/upload/2015StateDataBook%20\(revised\).pdf](http://members.aamc.org/eweb/upload/2015StateDataBook%20(revised).pdf)

NEW JERSEY'S LOOMING Physician Shortage

New Jersey faces a projected shortfall of 2,800 physicians by 2020. *
And the physician pipeline is running dry.



NEW JERSEY RANKS:

1st

in percentage of active international medical graduate physicians
{38.4%}

3rd

in the nation for doctors over 60
{32.7%}

31st

in medical school student retention
{34.1%}

37th

in medical students/100,000 population
{24.4}

45th

in the nation for doctors under 40
{13.3%}

.....
\$205,000 per median student loan debt for new physicians *
84 Percent of physicians carrying debt †

*N.J. Council of Teaching Hospitals
†Association of American Medical Colleges

Courtesy of New Jersey Hospital Association

There are numerous factors that make residency programs in New Jersey unique. New Jersey has a growing deficit in the ratio of active medical students to current physicians nearing retirement. Additionally, while the proportion of teaching to non-teaching hospitals is roughly on par with other states in the region, New Jersey has far fewer medical schools than other states (New York has 16 medical schools; Pennsylvania has nine).

Economic factors - both from the physician and hospital perspectives - are also barriers to physician retention in New Jersey. Survey data indicate that the mean average student debt load carried by a graduating resident for all specialties was in excess of \$185,000; the median nearly \$205,000.² In an area where physician salaries are among the lowest nationally, graduating residents and established physicians alike may look to other regions of the country to practice long-term.³

Meanwhile, personnel costs related to physicians (e.g., recruiting, salary, benefits) have risen in recent years. For a variety of reasons, New Jersey provider organizations must pay more in salary, benefits, and recruiting costs to attract and retain physicians to maintain appropriate physician workforce levels. Recent survey data show that nearly two-thirds of New Jersey hospitals have seen increased costs in physician recruitment, salary and benefits in 2015. The mean cost increase for these hospitals was 38.5 percent in 2015 alone.

Regulatory and legislative barriers also exist. Federally, the Balanced Budget Act of 1997 placed a cap on the number of Medicare-supported resident positions - known as "slots" - at 1996 levels. With few exceptions, this cap limits the ability of most teaching hospitals to expand or repurpose residency positions to meet changes in workforce or the needs of the community. When combined with other built-in costs of practice and living in New Jersey (e.g., liability insurance costs, property taxes, regulation, etc.), one can begin to understand the challenges of maintaining an adequate physician workforce in New Jersey.

² New Jersey Council of Teaching Hospitals. (2015). 2014 Comprehensive Data Report on Residents.

³ Peckham, C. (2016, April 1). Medscape Physician Compensation Report 2016. Retrieved from <http://www.medscape.com/features/slideshow/compensation/2016/public/overview#page=1>.

FEDERAL GME FUNDING

In recent years, the structure and formula used for federal support of GME financing has received increased scrutiny from policymakers and other experts in medical education and training. Two recent GME reform proposals raise particular concern for teaching hospitals:

- The Institute of Medicine committee released its proposal for GME reform⁴ in July 2014. It includes five recommendations that would fundamentally change resident physician training and care delivery, resulting in a 35 percent reduction to the average teaching hospital's GME payments.
- 2015 legislation introduced by House Committee on Ways and Means Chairman Kevin Brady (R-Texas), which would decouple IME payments from inpatient admissions in recognition of the changing landscape of healthcare delivery.

A 35 percent reduction in GME reimbursement would lead to cuts in key services such as trauma, clinical trials, burn units and pediatrics – frequently only available in the teaching hospital setting. For New Jersey, a 35 percent reduction in Medicare-supported GME funding would reduce New Jersey hospital funding by more than \$100 million annually.

Both proposals fundamentally misunderstand the concept of indirect medical education. IME is intended to help compensate for the higher costs associated with teaching hospitals, such as “learning by doing” and the greater use of emerging technology at these facilities. The IME adjustment is a percentage add-on to the DRG rate that varies on the intensity of a hospital's teaching program as measured by the ratio of residents to beds. Eliminating the formal interaction between Medicare admissions and IME payments would permit Medicare dollars to be distributed to providers not participating in the Medicare program. In addition, reducing or eliminating the IME adjustment could result in a significant decline in physician training programs nationwide, particularly in key primary care areas such as internal medicine. A 2011 ACGME study showed 68 percent of all teaching hospitals would reduce residency program size and scope with even a 33 percent reduction in IME payments. With New Jersey's supply of physicians dwindling, policymakers should look to add – rather than subtract – federal GME funding.

MEDICARE-SUPPORTED SLOTS

The cap on Medicare-supported residency positions - or “slots” - at 1996 levels is inflexible, and as a result, New Jersey's teaching hospitals are training over 300 residents in excess of the state's cumulative GME cap. To allow hospitals to adapt residency training programs to meet community health workforce needs, NJHA continues to support federal efforts to gradually expand the availability of additional Medicare-subsidized GME positions.

The Resident Physician Shortage Reduction Act of 2015 was introduced by U.S. Reps. Joe Crowley (D-N.Y.) and Charles Boustany (R-La.) in the U.S. House and Sens. Bill Nelson (D-Fla.) and Charles Schumer (D-N.Y.) along with Minority Leader Harry Reid (D-Nev.) in the U.S.

Senate. This measure would provide for the allocation of 3,000 additional slots annually over five years for a total of 15,000 slots. Half of these slots would be allocated to train residents in specialty physician programs where shortages may exist, with the remainder allocated with priority for hospitals in states with new medical schools, hospitals with programs emphasizing training in community settings, and hospitals demonstrating meaningful use. NJHA supports this important legislation, and urges members of the New Jersey delegation to co-sponsor S. 1148 and H.R. 2124.

The **Hospital Readmissions Reduction Program** was created by the ACA to penalize hospitals with higher-than-expected 30-day readmissions rates for certain conditions. Despite undertaking significant efforts to reduce readmissions and improve quality – including the NJHA Institute for Quality and Patient Safety-led Partnership for Patients hospital engagement network – hospitals in New Jersey are more likely to be penalized than those in other states. There is a growing mountain of evidence that the HRRP is disproportionately affecting hospitals with teaching programs. Nearly 94 percent of major teaching and 78 percent of non-major teaching hospitals received HRRP penalties in 2015. Research has shown that sociodemographic factors play a substantial role in patient readmissions. For teaching hospitals – many of which operate in urban environments – these socioeconomic factors as well as other factors outside of the hospital's influence can significantly impact the 30-day readmission rate. Bipartisan members of the Senate and House have introduced S. 688/ H.R. 1343 to more fairly apply readmissions penalties to providers serving the most vulnerable patient populations. Similar provisions were included in a legislative package that passed the House earlier this year. NJHA supports reforming the Medicare readmissions program to ensure its penalties are applied fairly to hospitals serving the most vulnerable patient populations.

The 340B program was created in recognition of providers – hospitals, health centers and others – serving the most vulnerable patient populations. It provides these healthcare entities with discounts on outpatient pharmaceutical products. Since its 1992 passage, Congress has made additional groups eligible for the program, including children's hospitals, freestanding cancer hospitals and hospitals with several rural designations (critical access hospitals, sole community hospitals). More than 20 New Jersey hospitals are 340B program participants. The program allows thousands of safety net providers to save over \$3.8 billion annually in drug costs, freeing up scarce resources for key service lines, enhanced technologies, clinics and other programs to serve their communities. Unfortunately, proposed guidance released last year could impose significant restrictions on 340B providers that could result in a reduction in key services such as outpatient infusion therapy. The “mega” guidance could also increase administrative burden for high-disproportionate share hospitals and create additional requirements for contract pharmacies. These proposed changes would raise the burden on hospital participants, particularly those entities eligible for the program via high DSH thresholds. NJHA opposes 340B changes. ●

⁴Eden, J., Berwick, D., & Wilensky, G. (Eds.). (2014). Graduate medical education that meets the nation's health needs. National Academies Press.