

# PHYSICIAN WORKFORCE: A Strategy for New Jersey



## Background/Facts

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 10<sup>th</sup> in the nation in resident full-time equivalents. Four medical schools – increasing to five by 2018 – graduate hundreds of medical students yearly. Combined, these New Jersey teaching hospitals and medical schools partner to educate and train the physicians of the future.

In addition to their commitment to training the state's future physicians, New Jersey's teaching hospitals and medical schools are also responsible for conducting 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<sup>1</sup>. On the other side of the age spectrum, only 13.3 percent of New Jersey physicians are under 40, the 5<sup>th</sup> lowest percentage in the nation.
- Compared with other Mid-Atlantic states, New Jersey is short on medical students. New Jersey has 24.4 medical students per 100,000 population – 37<sup>th</sup> 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).

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<sup>1</sup> 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 York and Pennsylvania also rank 1<sup>st</sup> and 2<sup>nd</sup> in the nation in total residents with more than 16,000 and nearly 7,000 current residency positions, respectively. New Jersey maintains slightly more than 3,000 residency positions.
- New Jersey's medical education community is working to reverse these alarming trends. New Jersey's fourth medical school – Cooper Medical School of Rowan University – will graduate its first class later this year. A fifth medical school – Seton Hall Hackensack Meridian School of Medicine - is slated to begin enrollment next year, and other efforts are underway to ensure New Jersey has the undergraduate medical education capacity necessary to serve current and future patients.

## 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) is made 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 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.

## Barriers

Combined with medical student and resident retention rates at or near the national average, this data underscores the need for a new path forward to ensure a robust physician workforce for generations to come. 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

There are numerous factors that make residency programs in New Jersey unique. As referenced above, there is 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<sup>2</sup>. 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<sup>3</sup>.

Meanwhile, personnel costs related to physicians (e.g., recruiting, salary, benefits) have risen in recent years. For a variety of reasons, in order to maintain appropriate physician workforce levels in the state, New Jersey provider organizations must pay more in salary, benefits, and recruiting costs to attract and retain physicians. Recent survey data show that nearly 2/3 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 in order to meet changes in workforce or the needs of the community. In addition, as the federal budget continues to expand, policymakers will be pressured to find additional cost savings in Medicare and other health programs. Medicare's continued GME support of teaching hospitals is not guaranteed in this era of budget austerity

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

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

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. New Jersey requires a bold, new strategy to ensure its long-term physician supply is sufficient to meet the growing needs of its patient population.

## **Solutions**

In order to develop policy solutions to any shortages in physician supply, NJHA beginning in 2015 convened a workgroup of interested member representatives from the medical school and teaching hospital communities. The charge of the workgroup was simple: analyze, assess and produce options for consideration by the NJHA policy-making process. The workgroup focused its attention on state-specific solutions to improve New Jersey's reputation as a destination for physician practice.

Solutions developed by the workgroup were focused on legislation; other efforts (e.g., a training site clearinghouse) were also suggested and are to be separately considered and implemented. The solutions endorsed by the workgroup and the NJHA Teaching Hospitals Constituency Group include the following:

1. Increased/Enhanced Physician Loan Redemption Opportunities
2. State "Conrad" 30 J-1 Visa Waiver Reform
3. Preferential Tax Treatment for New Physicians
4. Targeted Funding in Areas/Specialties of Need

## **Increased/Enhanced Physician Loan Redemption Opportunities**

While the state's Primary Care Practitioner Loan Redemption Program has helped some primary care providers remain in the state post-residency, additional resources are necessary to forestall a potential physician shortage. Hospitals are stepping up internal efforts – so-called "skin in the game" – with hospital-financed loan redemption programs for qualified physician practitioners. These loan redemption programs ensure physicians trained in New Jersey stay in New Jersey long-term to live and practice medicine.

The Primary Care Practitioner Loan Redemption Program can be retooled to meet the future healthcare needs of New Jersey patients. NJHA has supported legislative initiatives to expand the program to additional underserved areas. In addition, NJHA has supported legislation to ensure at least a portion of the current loan redemption program funding is directed toward needed primary care physician practitioners. Moreover, NJHA supports recent legislative efforts creating a new loan

redemption program specific to psychiatry, perhaps the specialty in greatest need throughout the state.

New Jersey's resident physicians have consistently indicated economic factors as a reason for leaving the state post-residency. State-supported loan redemption programs can be an effective tool to ensure more of our state's residents are remaining in New Jersey to practice long-term. Residents accepting tuition reimbursement are required to practice in areas of need, providing access to primary care and preventive services for underserved populations. NJHA supports efforts to maintain and expand our physician population. Loan redemption expansion – whether through the current program or specialty-specific programs – are proven tools to keep these physicians in New Jersey.

## **State "Conrad" 30 J-1 Visa Reforms**

The State "Conrad" 30 program was created by Congress in 1994 to provide for additional physician workforce capacity in federally-designated underserved areas and areas facing health professional shortages. Named for former North Dakota Senator Kent Conrad, the program provided each state with 30 J-1 visa waiver "slots." Typically, foreign medical graduates with J-1 visas in residency training programs in the United States are required to return to the resident's home country for a period of two years post-residency. The Conrad 30 program allows states to grant waivers to certain individuals to remain in the United States post-residency. Legislation passed in 2008 allows for 10 of the 20 available slots to be awarded at the discretion of individual state programs.

Given the number of J-1 visa holders in New Jersey residency programs – perhaps more than 200 according to a recent survey – keeping these physicians in New Jersey could be an important part of the state's physician retention solution. Unfortunately, New Jersey's Conrad 30 program has lagged behind other states in the region. First, the burdensome application process steeped in legalese is a frequent deterrent for hospitals interested in supporting program applicants. Second, New Jersey's Conrad 30 program places additional restrictions – above and beyond the federal statutory requirements – on program participants. Finally, the state underutilizes federal designations available to broaden the service areas interested applicants can serve.

NJHA supports reforming the State Conrad 30 program to help fill future physician workforce gaps. Administrative, regulatory and/or legislative action could help provide a solution to this issue.

## **Preferred Tax Treatment for New Physicians**

Practicing medicine in New Jersey can be more expensive than other states. As referenced, physicians leaving New Jersey for other states post-residency cite economic factors as a reason for establishing their practice in another state. Other factors, such as regulatory barriers or Medicaid reimbursement, can have an impact on a physician's decision to stay in New Jersey to practice.

As a way to entice physicians to remain in the state post-residency, legislation has been introduced in recent years allowing for a limited tax deduction and/or credit for new individual physician practices. The purpose behind this preferential tax treatment is twofold: first, the positive economic effect would be attractive for New Jersey resident physicians uncertain of their post-residency practice plans. Second, the ancillary benefits of a physician practice to the state (e.g., taxes paid, practice employees) would be an economic stimulus to the state of New Jersey. Combined, the tax deduction could help alleviate the state's physician shortage while simultaneously providing a benefit to both the state and the physician's community. NJHA supports legislative efforts to encourage more physicians to remain in state to practice, and a tax deduction/credit for these physician practices would help achieve this goal.

## **Targeted Funding in Areas/Specialties of Need**

As referenced, New Jersey has made significant financial incentives to improve the retention of residents and medical students. Some efforts, such as the state's significant contribution to the residency training through Medicaid GME support of training programs, have allowed for an increase in overall residency positions in the state. Still other efforts, such as the enhanced Medicaid physician payment rates included in the last two state budgets, have aimed to help increase access to necessary primary care and specialist services for Medicaid beneficiaries. Still, other efforts need to be made to ensure New Jersey is training the specialists and primary care physicians to best meet the state's healthcare needs.

While federal funding for GME is inflexible, state funding can perhaps be targeted to communities lacking appropriate access to physician-level health services. To this end, some have suggested utilizing new funding to target either new programs (through "start-up" costs to include technology, personnel, etc., necessary to start a residency program) or existing programs training physicians where there is a demonstrated need in the state. Funding sources could include not only new hospital subsidy funding, but also funding through public or private grants, demonstrations, pilots or payers. New funding would allow the state's teaching institutions to become more nimble in their approach to training our state's future physicians. Given the projections of a deficit in the state's physician workforce supply pipeline, additional funding would help forestall the out-migration of physicians trained in New Jersey's hospitals.

## Conclusion

The New Jersey healthcare community – from educators to hospitals, regulators and policymakers – are committed to ensuring a strong and viable state physician workforce. The state’s strong support for the critical mission of New Jersey’s teaching hospitals is helping this commitment become a reality. The administration and legislature have been advocates for improving the conditions for residency training in the state through an enhanced GME subsidy through the state Medicaid program. This workforce investment has allowed for a significant expansion in the number of physician trainees in the state’s teaching facilities.

Nevertheless, more needs to be done to bolster our state’s physician workforce for future generations. The above proposals would provide the state with additional resources to meet the changing needs of the patient population. NJHA and its teaching hospital members are committed to the important mission of training the state’s next generation of physicians. These proposals would help achieve this important goal.