



NEW JERSEY HOSPITAL ASSOCIATION
**TEACHING HOSPITAL
FEDERAL PRIORITIES 2017**

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Background: GME and New Jersey

New Jersey continues to be a national leader in academic medicine. Forty-four hospitals – and growing – have approved graduate medical education (GME) programs. Working with the state’s four medical schools, these teaching facilities are instrumental in ensuring an adequate long-term physician workforce pipeline. These institutions not only maintain the state’s physician workforce pipeline but also conduct groundbreaking medical research and clinical trials. Most importantly, the state’s academic medicine community plays a critical role in delivering patient care to the state’s most vulnerable patients. In short, the state’s medical education community is a key cog in the healthcare delivery system that must be protected.

What is GME? Clinical settings are key sites for the education of future physicians. Typically, teaching hospitals and associated ambulatory settings provide an educational environment for the training of resident physicians. Once residents have graduated from medical school, these doctors-in-training go on to several years of supervised, hands-on training. Some choose to specialize post-residency in a non-primary care fellowship such as cardiology or a pediatric subspecialty. GME 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. Receiving training from an accredited GME program is a requirement for physicians wishing to practice in the United States.

GME AND NEW JERSEY: Facts and Figures

3,400 number of resident full-time equivalents training in New Jersey

7,000 number of resident full-time equivalents training in Pennsylvania

16,000 number of resident full-time equivalents training in New York

32.2 residents/100,000 population in New Jersey

61.6 residents/100,000 population in Pennsylvania

81.5 residents/100,000 population in New York

5 the number of NJ-based medical schools: Cooper Medical School of Rowan University, Rutgers Robert Wood Johnson Medical School, Rutgers New Jersey Medical School, Seton Hall-Hackensack Meridian School of Medicine, Rowan School of Osteopathic Medicine

1 New Jersey’s national rank by percentage of active international medical graduate physicians and residents

3 New Jersey’s national rank in percentage of physicians over the age of 60 (32.7 percent)

45 New Jersey’s national rank in percentage of physicians under the age of 40 (13.3 percent)

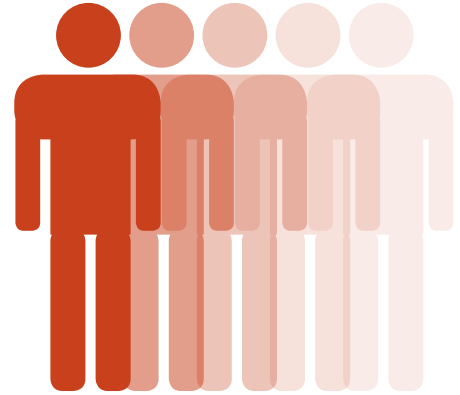
\$210,822 average individual debt for a resident graduating from a New Jersey residency program

74% retention rate for graduating residents who attended high school, college, and medical school in New Jersey

40% overall 2017 resident retention rate

Source: AAMC & 2017 Resident Exit Survey.

PHYSICIAN SHORTAGE CASE STUDY: Psychiatry



1,608

licensed
psychiatrists
in the state of
New Jersey
(all specialties)

83

child
psychiatrists
in the
state

32

child
psychiatrists
accepting new
Medicaid patients
(39 percent)

800,000

approximate
number of
NJ FamilyCare
beneficiaries
under the
age of 21

Medical Education Issues

SLOTS: The Balanced Budget Act of 1997 placed a cap on the number of available Medicare-supported GME “slots.” The inflexibility of the cap limits the ability of teaching hospitals to expand or repurpose resident positions to address changes in physician workforce or the needs of the community. Statewide physician workforce data continues to foretell the possibility of a physician shortage. As experienced physicians consider retirement, retaining a higher proportion of younger physicians is paramount to the state’s workforce supply.

Thankfully, U.S. Reps Ryan Costello (R-Pa.) and Joe Crowley (D-N.Y.) have introduced legislation to increase the availability of Medicare-supported GME slots. H.R. 2267, the Resident Physician Shortage Reduction Act of 2017, would provide for the allocation of 3,000 additional slots annually from 2019 through 2023 for a total of 15,000 slots. Senators Bill Nelson (D-Fla.), Charles Schumer (D-N.Y.) and Dean Heller (R-Nev.) have introduced similar legislation (S. 1301) in the United States Senate. H.R. 2267/S. 1301 would direct the Centers for Medicare and Medicaid Services to allocate one-third of the new positions to hospitals training at least 10 residents beyond their current GME caps based on the hospital’s proportion of all residents nationally training over GME caps. Half of the new slots would be used to train residents in specialties where shortages may exist using a methodology that would prioritize hospitals in states with new medical schools. Finally, the legislation directs the U.S. Government Accountability Office to complete a report on GME focusing on increasing the diversity of the physician workforce.

NJHA supports this important legislation and urges members of the New Jersey delegation to co-sponsor H.R. 2267/S. 1301.

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LOAN FORGIVENESS: Graduating residents with confirmed post-residency practice plans frequently cite economic factors as reasons for remaining in a given area to practice. Many states – including New Jersey – have utilized state resources on loan redemption or tuition reimbursement programs to help retain graduating residents. As an example, Governor Christie signed legislation into law earlier this summer to provide for a tuition reimbursement program specifically for psychiatrists looking to remain in the state to practice.

Federal policymakers have also looked at loan redemption programs to encourage providers to practice in areas with underserved or vulnerable populations. Congress created the Public Service Loan Forgiveness (PSLF) Program in 2007 to allow loan forgiveness for the balance of certain federal loans following 10 years in public service. Program participants are required to make 120 qualifying monthly payments while working full time for a 501(c)(3) or another qualified employer. The PSLF Program allows physicians and other health professionals the opportunity reduce educational debt while expanding access to health services in underserved areas.

NJHA supports the PSLF Program and urges Congress to preserve this important tool for patients and practitioners alike.

Other Teaching Hospital Issues

340B: The 340B Drug Pricing Program has been critical in helping New Jersey's safety net hospitals expand access to lifesaving treatments for vulnerable patient populations. The 2018 outpatient prospective payment system final rule reduces Medicare payments for 340B drugs from the current rate of average sales price (ASP) plus six percent to ASP minus 22.5 percent.

340B drug purchases account for less than 3 percent of the \$457 billion in annual drug purchases made in the U.S., and the savings 340B covered entities receive are reinvested in programs that enhance patient services and access to care. Hospitals that participate in 340B provide 60 percent of total uncompensated care, even though they make up only 36 percent of the nation's hospitals. Moreover, in New Jersey, only hospitals serving a significant percentage of low-income patients are eligible to be 340B covered entities. Nineteen of New Jersey's 20 current 340B hospital participants are also teaching hospitals.

The CMS Advisory Panel on Outpatient Payment recommended that the agency not finalize for 2018 the proposal that would cut Medicare payments for drugs acquired under the 340B program and that the agency should collect data from public comment before taking any action. Scaling back the 340B

program punitively targets safety net hospitals serving vulnerable patients without addressing the larger issue of escalating pharmaceutical costs.

Thankfully, U.S. Reps David McKinley (R-W.Va.) and Mike Thompson (D-Calif.) have introduced bipartisan legislation to prevent CMS from implementing this dramatic reduction in reimbursement for New Jersey's 340B program participants. H.R. 4392 would reverse the CMS final rule that reduces Medicare payments by \$1.6 billion nationally to non-profit hospital 340B covered entities.

NJHA supports H.R. 4392, and urges delegation members to cosponsor this important legislation to ensure its inclusion in any year-end legislative package.

MEDICAID DSH: New Jersey's teaching hospitals provide care to some of the state's most vulnerable patient populations. As a result, policy proposals that impact the healthcare safety net can have a disproportionate impact on our state's teaching institutions. As an example, Medicaid makes disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid and other low-income patients. The federal government reimburses states for a portion of their Medicaid DSH expenditures based on each state's FMAP. Unlike most other Medicaid spending, DSH funding is capped with each state receiving an annual DSH allotment.

Under the Affordable Care Act, federal DSH allotments were scheduled to be reduced to account for an anticipated decrease in uncompensated care as a result of an increase in the number of people with insurance. While the implementation of the reductions has been delayed five times, nationwide DSH cuts totaling \$2 billion in FY 2018 and \$43 billion over the next eight years began October 1.

According to the Medicaid and CHIP Payment and Access Commission (MACPAC), hospitals serving uninsured and Medicaid beneficiaries still desperately need DSH funding despite the recent reductions in uncompensated care costs. The magnitude of the scheduled DSH cuts would devastate New Jersey safety net providers and threaten the services they provide to patients and communities.

Given these consequences, coupled with the uncertainty of the future of the ACA and levels of health insurance coverage, NJHA urges Congress to further delay implementation of the Medicaid DSH cuts.

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