Michigan Brain Drain

How Many Physicians Are We Losing From Underfunded GME?

By Alicia Gallegos

If given the choice, second year medical student Nicolas K. Fletcher would complete his residency training in Michigan and remain in his beloved Midwestern state to start his career as a practicing physician.

However, the Michigan State University College of Human Medicine student knows his ideal residency location may be out of reach because of a lack of graduate medical education (GME) funding. Fletcher will soon be vying with hundreds of other doctors for a limited pool of state residency spots – a reality that, unfortunately, may force him elsewhere.

"One of the discussions my wife and I have had is, although we're both out-of-state students, we've come to really love Michigan and appreciate what western Michigan has to offer," said Fletcher, Chair of the MSMS Medical Student Section and an expectant father. "I would like the opportunity to stay in Michigan. GME [funding] should not be one of those issues influencing my decision of where I can go. You should not have to deal with the fact they just don't have enough spots."

Frustration among Michigan physicians, medical students and hospitals is growing as the federal freeze on residency slots continues to drive talented young doctors out of the state. The government in 1997 placed a cap on the number of Medicare-supported residency spots in the US, a limit tied to the number of residents that teaching hospitals reported in 1996. The cap means that despite a growing number of medical graduates across the country, the same limited number of training slots remain. The freeze is even more challenging for states such as Michigan that recently opened new medical schools.

(l to r) Nick Fletcher, MSMS President Kenneth Elmassian, DO; and Wayne State University School of Medicine students Sarah Gorgis, and Corey Lake, at MSMS Student Lobby Day last fall.

"In the last few years, we have opened three new medical schools: Oakland [University William Beaumont], Western Michigan University and Central Michigan University," said John E. vanSchagen, MD, program director for the GRMED/MSU family medicine residency and associate chair for the Grand Rapids Michigan State University College of Human Medicine department of family medicine. "The remaining traditional schools have all expanded their class sizes dramatically. The bottleneck comes back to GME. We're coming up on 20 years without an increase in the number of slots that have been available in our state."

Physician leaders continue to examine potential solutions to the GME dilemma, including legislative remedies, new residency structures and alternative GME funding sources – but questions remain as to whether these solutions are feasible and if such repairs will come in time.

Residency Funding by the Numbers

Nationally, Medicare pays about $10 billion toward GME, both through direct and indirect payments. Direct payments refer to expenses for resident salaries and supervising physicians' time. Indirect payments subsidize other hospital costs associated with running training programs. Indirect payments are based, in part, on the number of residents a hospital trains and the number of Medicare patients it treats.

Michigan receives close to $168 million annually from Medicare. The state itself pays about $54.7 million.

Michigan directs a portion of state funding to GME as well. State Medicaid programs are not obligated to pay for GME, but most states historically have made such payments under their fee-for-service programs. A 2012 AAMC report ranked Michigan among the 15 states that contribute the highest GME payments. Michigan is one of only nine states that include Medicaid GME payments in its capitated payment rates to managed care organizations. In 2012, Michigan paid $163 million toward GME, according to AAMC data.

Despite its contribution, Michigan is providing significantly less for GME than in previous years. In 2011, state lawmakers cut six percent from its GME funds. Further state cuts could be on the horizon. Meanwhile, the Obama administration has proposed cutting $11 billion from GME over the next decade in its fiscal 2014 budget. The cuts would represent about 10 percent of Medicare's contribution to GME.

"The national outlook is dismal," said Richard Cooper, MD, director of the Center for the Future of the Healthcare Workforce at New York Institute of Technology and a senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania. He is a former dean of the Medical College of Wisconsin.

"You have major advisors of the president arguing that [funding] should not be increased," Doctor Cooper said. "You have this body of opinion among a group of economists and policy-makers who, in our view, are totally out of touch with reality and therefore continue to argue against expanding supply. It's really appealing to Congress because to do nothing doesn't cost anything."

Nationally, more than 500 medical school graduates are already unable to match with a residency annually, according to American Medical Association data. That number is expected to grow as the pool of medical school graduates rises.

The value and importance of GME is becoming lost as the federal government focuses on thinning its budget, said Atul Grover, MD, PhD, AAMC chief public policy officer.

"The major problem right now is a climate of deficit reduction in DC where Congress is looking to cut spending and not looking at the long-term need to invest in the workforce," he said.

New doctors provide most uncompensated care

Medical residents are well worth their training expenses, physician experts say. They provide substantial medical care for much less than their fully-trained physician counterparts.

"Residents work up to 80 hours per week and are typically paid less than $50,000 per year, representing an incredible value in health care delivery," said Laura Appel, vice president of federal policy and advocacy for the Michigan Health & Hospital Association. In addition, "residencies typically are located at hospitals serving disadvantaged populations. These doctors are essential to caring for Medicaid patients and those without health insurance."

In 2013, Michigan's Medicaid caseload was close to a record high of nearly two million people. An additional 1.2 million patients lacked health insurance, Appel said. In fiscal year 2011, [the most recent annual data available], Michigan hospitals provided nearly $1.9 billion in uncompensated care, including more than $882 million in financial assistance at cost and uncollectable funds. Nationally, teaching hospitals provide close to 40 percent of all charity care in the US, according to AMA data.

Because of the necessity of residents, hospitals often use a portion of their own budget to pay for additional slots or costs associated with residencies, said Michael J. Ehlert, MD, a Detroit urologist and member of the Michigan State Medical Society Board of Directors. But budget constraints are forcing many hospitals to pull back on extra residency funding, he said.

"As hospitals make less and less money and there is [federal] pressure on hospitals to basically not spend as much, the money is not going to be there anymore [for residents]," he said. "There's not enough fat on the meat. It's harder for them to fund these spots."

The Impact of Growing Graduates, Stagnant Residencies

When it comes to residency slots, Michigan has long had one of the highest numbers of spots in the country.

"We're pretty high on the list," said Peter Coggan, MD, MSEd, vice president and chief academic officer for CHE Trinity Health in Livonia. "[Michigan] has had more teaching hospitals, the

Primary Medical Care Health Professional Shortage Area (HPSA) Designations

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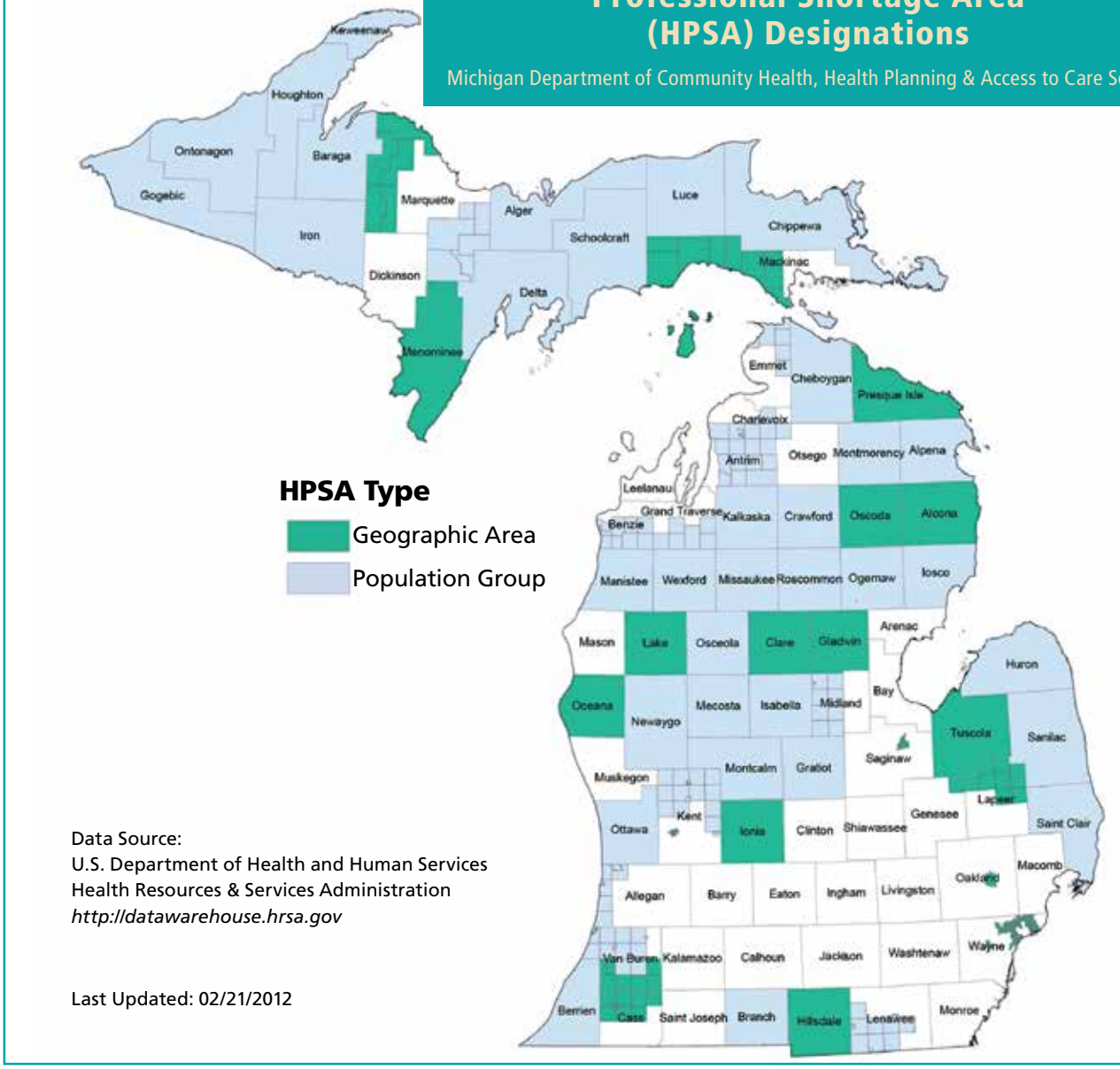

population density is greater and there's more of a tradition of teaching. [The state] has had residency programs in their hospitals going back to the 1940s and 50s."

In the 2013 match, Michigan had a total of 1,261 allopathic residency slots and 478 osteopathic residency spots, according to data from the National Resident Matching Program (NRMP) and the American Osteopathic Association.

In the past, the ratio of Michigan medical students to residencies in the past, allowed for more graduates to find residencies in-state. However, like other states with new medical schools, that proportion is quickly shifting.

"It's not [a bad] thing that we're trying to make opportunities available for talented young women and men to get trained," as doctors, said Theodore B. Jones, MD, FACOG, residency program director, obstetrics and gynecology at Oakwood Hospital and Medical Center in Dearborn. He serves on MSMS Board of Directors. "But when that training is over, and they go on to post-graduate training, the [question is], are we going to have enough slots?"

Research shows that medical students commonly practice in the area where they complete their residency, adds Andrew Moriarity, MD, senior resident in radiology at Henry Ford Health System. Thus, a lack of residency spots means graduates who move for their graduate training likely won't be returning, he said.

"A lot of the medical school and residency education can be viewed as an investment in the state," said Doctor Moriarity, a graduate of Wayne State University School of Medicine. "It would be good for the [legislators] to realize that by [increasing] GME funding, they're actually encouraging those same doctors to stay, rather than moving elsewhere."

Along with Michigan medical school graduates, the scarcity of residency slots and growing graduate pool also presents challenges for international medical school graduates.

In 2013, IMGs accounted for more than one third of the residency applicant pool in the US, including 7,568 non-US citizen IMGs and 5,095 US citizen IMGs, according to the NRMP. In Michigan, IMGs make up about 10 percent of the physician workforce, according to a 2013 AMA-IMG Section Governing Council report. The state also had the second highest number of physicians holding J-1 visas in the 2010-2011 academic year

at 552, according to the report. Only New York had more J-1 physicians at 1,227.

But international medical graduate advocates are concerned that when push comes to shove, IMGs are most likely to miss out on residency spots.

"The priority of the [GME] funding is going to be for US graduates," said Rima Jibaly, MD, a Flint pediatric gastroenterologist who serves on the MSMS International Medical Graduate Section Governing Council. "We feel that it's going to affect international graduates more than anybody else."

Whether residency programs choose US-born applicants over IMGs will depend on the program and each specific school's goals, Doctor Jones said. But, it's possible gifted international doctors will be overlooked because of limited residency spots, he said.

"I have found through the years that there are some pretty extraordinary international medical gradates that are in the applicant pool," he said. "I have had no regrets considering them for training and watching them develop into really outstanding doctors. It really just depends on how you want to look at the pool of talented individuals."

Examining Potential Residency Remedies

Various solutions have been proposed to address the GME funding dilemma, namely pushing Congress to lift the freeze on federally-funded residency slots.

Senator Moolenaar (center) responds to concerns of visiting medical students at the Capitol on MSMS Student Lobby Day last fall.

Medical Loan Repayment Bill Clears Committee

In January, a bill that would modify a program that re-pays student loans for certain physicians in underserved areas moved out of the Senate Appropriations Committee with amendments. Senate Bill 648, sponsored by Sen. John Moolenaar (R-Midland) and supported by MSMS, would remove the four-year limit on loan repayments, increase the maximum annual loan repayment, and establish a lifetime cap on loan repayments. The idea, according to the bill sponsor, is to incentivize more medical students to choose to practice primary care in rural and underserved parts of the state. The bill also would permit the Michigan Department of Community Health to give preference to physicians studying general practice, family medicine, obstetrics and gynecology, pediatrics, or internal medicine. Watch *Medigram* for further developments.

Learn more about state and federal loan repayment programs at *www.msms.org/gme*.

The AAMC advocates that the government increase GME positions by at least 15 percent, a figure that would allow teaching hospitals to train another 4,000 physicians a year.

"We have to work with the federal government to increase the number of funded positions so that we can actually have more training positions in the state," Doctor Coggan said. "There have been several bills in the last few years advocating for an increase in federal funding for positions, but they haven't gone anywhere because those bills have been published at a time" when there were serious concerns about the total federal budget.

Most recently, US Reps. Joe Crowley (D-New York) and Michael Grimm (R-New York), reintroduced the Resident Physician Shortage Reduction Act of 2013. The act would create 15,000 new GME slots over five years. As of March 2013, the bill was assigned to a congressional committee that will consider it before potentially sending it on to the House or Senate.

"Our country needs us to do all we can to alleviate the coming doctor shortage, yet an outdated limit on the number of doctors that can be trained ties the hands of our medical schools and our teaching hospitals," Crowley said in a statement. "Increasing the number of residency slots, along with maintaining sufficient resources for our teaching hospitals, will enable us to continue developing the highly-trained physician workforce we need."

Paying for More Slots

Finding alternative forms of funding could also help pay for more residency slots. Doctor vanSchagen notes that some insurers and third-party payers already subsidize some portion of medical education. Expanding these contributions could potentially help solve the shortfall.

Other theorists have suggested shortening the length of residency, thereby freeing up some open spots and allowing for more residents to train at a time, Doctor Cooper said. But he argues that medical residents need all the training they currently receive.

"That's not a good idea," he said of shortening residency. "Medicine is getting more complicated rather than less complicated."

Redistributing residency funding to target the specialties most in need of physicians is another idea. The strategy would be to ensure the proportion of specialists in training comes closer to meeting physician workforce needs, Doctor Coggan said. "If we're going to need more primary care physicians, perhaps funding for primary care residencies would be favored," he said. "The same might be true for general surgery. We're approaching a bit of a crisis of the numbers of surgeons. Funding should be directed toward those specialists of need."

Michigan, meanwhile, needs to focus on how best to retain its medical school graduates, Doctor vanSchagen said. For example, Michigan could create a loan repayment program or other special opportunities for physicians and young families who want to stay in the state, he said.

"It would behoove the state to keep the students and residents that we train," he said. "We need to keep them home. They know the population. They know the medical system. We need to keep them here, rather than Michigan being an exporter of talent." MM

The author is an Indiana-based medical writer.