Letter of Support for Graduate Medical Education Cap Reform:

A Call for Cap Flexibility in One of America's Most Underserved Regions

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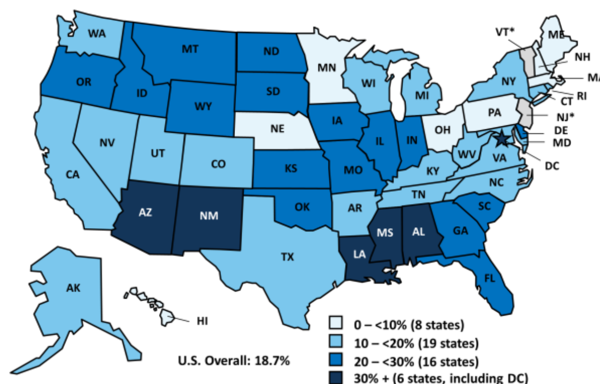
Introduction

As a National Health Service Corps (NHSC) Scholar, I completed my internal medicine residency in Miami Beach and relocated to medically underserved rural north Mississippi. The realities of practicing medicine with the limitations of resources, paucity of physicians, complex socioeconomic and clinical conditions were challenging and rewarding. I wanted to make a lasting impact on the access and delivery of care in the region, and I partnered with Magnolia Regional Health Center (MRHC) in Corinth, MS to start an internal medicine residency program in 2008. As various health care demographics show, Mississippi is one of the poorest and unhealthiest states in the country.

Figure 1

Percent of Population Residing in Primary Care Health Professional Shortage Areas (HPSAs), 2014



NOTES: Includes populations in Geographic Area and Population Group HPSAs, but not Facility HPSAs.
*HRSA data show no population living in Geographic or Population Group Primary Care HPSAs in NJ and VT.
SOURCE: KCMU analysis based on HRSA *Designated Primary Care Health Professional Shortage Area Statistics* as of August 12, 2014 and the March 2014 Annual Social and Economic (ASEC) Supplement to the Current Population Survey (CPS).

As the program grew to our full cap amount of six residents per year (18 total in the program), we started to have a truly meaningful impact on our community and region. We created an outpatient resident continuity clinic that provides care to indigent patients, with laboratory services, imaging, and medications all available with a sliding scale for payment and totally free of charge

to many. Our residents and faculty members provide care for all types of patients, in both the inpatient and outpatient setting, with complex care needs and who would otherwise have critical limitations to health care access. Moreover, we trained several residents who completed fellowship training in various specialties and ultimately returned to Corinth as the first physicians ever to deliver their respective specialty care in the region. As the graduate medical education (GME) program grew, patients could finally get the care they needed and the hospital (MRHC) expanded from 165 beds to 200 beds. Today, I can confidently say that we could easily expand by another 100 beds based on the needs of the region. This growth in the hospital's average daily census is clearly related to the introduction of GME at the institution. MRHC is the largest employer in Alcorn County, so this growth brought a great economic impact to the region. Governor Phil Bryant has made it a point to recruit and retain physicians in the state of Mississippi. The governor's office stated that for every physician brought to the state, a $2 million per year economic gain could be expected. Unlike most other internal medicine residency training programs whose graduates generally do not practice in primary care or rural underserved areas, the graduates of MRHC have remained in this rural underserved area to deliver care. In all, 69 percent of our graduates (22 of 32) have contracted to practice in rural underserved regions after completing training and 56 percent of our graduates (18 of 32) have decided to remain in primary care after graduation. This influx of physicians has brought $44 million/year to the region by the governor's estimate. Many of the graduates have returned to become faculty for our program and now assist in the education of trainees matriculating into our program. These aforementioned facts prove that graduate medical education can have a significant impact on the health of an entire region. The only problem is that we need to grow, and unfortunately, we cannot get the funding we need due to Center for Medicare and Medicaid Services' (CMS) cap on GME funding.

Challenge

When I first started the program in 2008, I had no additional faculty and only three applicants for the six spots in the program. However, through the years, our program has matured into an excellent academic institution. We have had 30 of our 32 graduates (94%) pass their internal medicine board exam on their first attempt. This is impressive when compared to the national average pass rate of 90%. Additionally, we progressively improved upon our In-Service Exam scores from almost the worst in the country on our first attempt in 2008 to number 3 nationally in 2017. This is mentioned to prove that residents trained in rural underserved regions can achieve excellent medical education when compared against traditional, heavily funded urban academic institutions.

Furthermore, the success of our program has made it a sought after training institution for graduating medical students. As I stated previously, we had only three applicants for our six

spots in 2008; this year we have had over 700 applicants for these same six spots! In addition to the aforementioned benefits our graduates have on the region, our current residents are also extremely important for the delivery of care to the sickest and most impoverished patients in the sickest and most impoverished state in the union. Our training program could easily accommodate an increase in our class size from 6 to 12 residents per year which would double the size of the three year training program from 18 to 36. We have a proven track record of success and know that this increase in program size would have a substantial positive impact on the region. The only problem is that we need to grow, and unfortunately, we cannot get the funding we need due to CMS's cap on GME funding.

Solution

The only current solution we have to increasing the size of our program is to wait for CMS to redistribute cap funding when programs close or fail to utilize cap dollars over a prolonged period. We have no idea if or when this option will recur so we cannot effectively plan and build the necessary infrastructure to support expansion. For this reason, when I learned that Applied Policy was calling for reform of GME funding, I was intrigued and immediately supportive of their initiative. Their executive summary listed many critical elements that speak to me and my institution daily. These elements include:

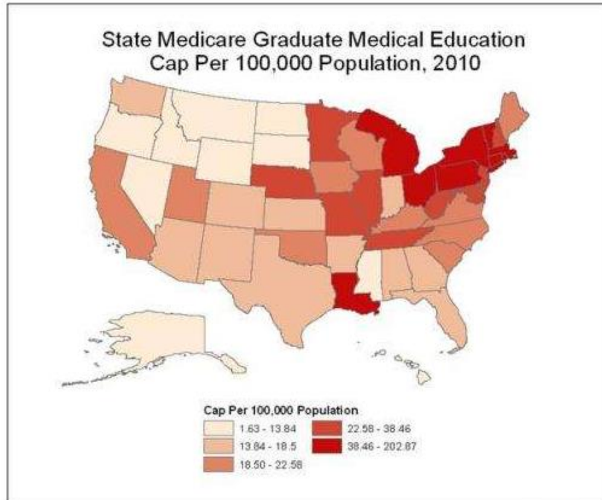
"Cap-flexibility benefits our national GME system in many ways, including, but not limited to:

• Providing life-saving opportunities for new teaching institutions to further develop residency programs and secure the resources necessary to launch and/or scale-up training capabilities. Additional time is vital to ensuring that teaching institutions in under-resourced areas will be able to build-up to a level necessary to meet regional needs.

• Alleviating regional physician shortages by providing time for institutions to add primary care and/or specialty and subspecialty residencies in shortage.

• Boosting the return on investment for Medicare, local communities, states, medical schools, and the hosting teaching hospital. By expanding training opportunities, the likelihood of physicians remaining in the underserved area to practice increases.

• Helping address the maldistribution of physicians and GME resources across the country. Cap-flexibility incentivizes the establishment of GME programs in areas of high-need without taking resources away from other areas. As residents tend to practice where they train, adding, developing, and incentivizing the establishment of programs at teaching institutions located in underserved, under-resourced, and rural areas will help address the current maldistribution of physicians across the country. Over time, a well-tailored cap-flexibility policy will better align the



This map shows the number of Medicare-sponsored medical residents per 100,000 people, per state. The research shows that a disproportionate share of the nation's funding for Graduate Medical Education goes to certain states, mostly those located in the Northeastern United States. Credit: The George Washington University School of Public Health and Health Services

supply of physicians with demand by creating a more diverse and equal distribution of GME training resources, programs, and physicians across the U.S.”

The only issue that I have with Applied Policy’s proposal is that they are asking for a five-year extension on the current five year CMS cap on GME funding. I would implore CMS to remove the limit altogether on the cap for rural and underserved GME funding. Unfortunately, the current funding of GME by CMS mirrors the maldistribution of physicians nationally. Like physician practice locations, most GME funding is aimed at urban academic institutions. New York state received 20 percent of all of CMS's graduate medical education funding while 29 states, including places struggling with a severe shortage of physicians, got less than 1 percent, according to a report published by researchers at the George Washington (GW) University School of Public Health and Health Services (SPHHS). We have a proven track record of being able to train excellent physicians in rural Mississippi that have remained in the region to provide care for human beings that desperately need it. Please allow us to increase our program size so we can continue to have a greater positive impact on this important region. We urge CMS to remove the cap on GME funding entirely for programs like ours so that we can continue our mission to achieve health care equality for people who urgently need it.