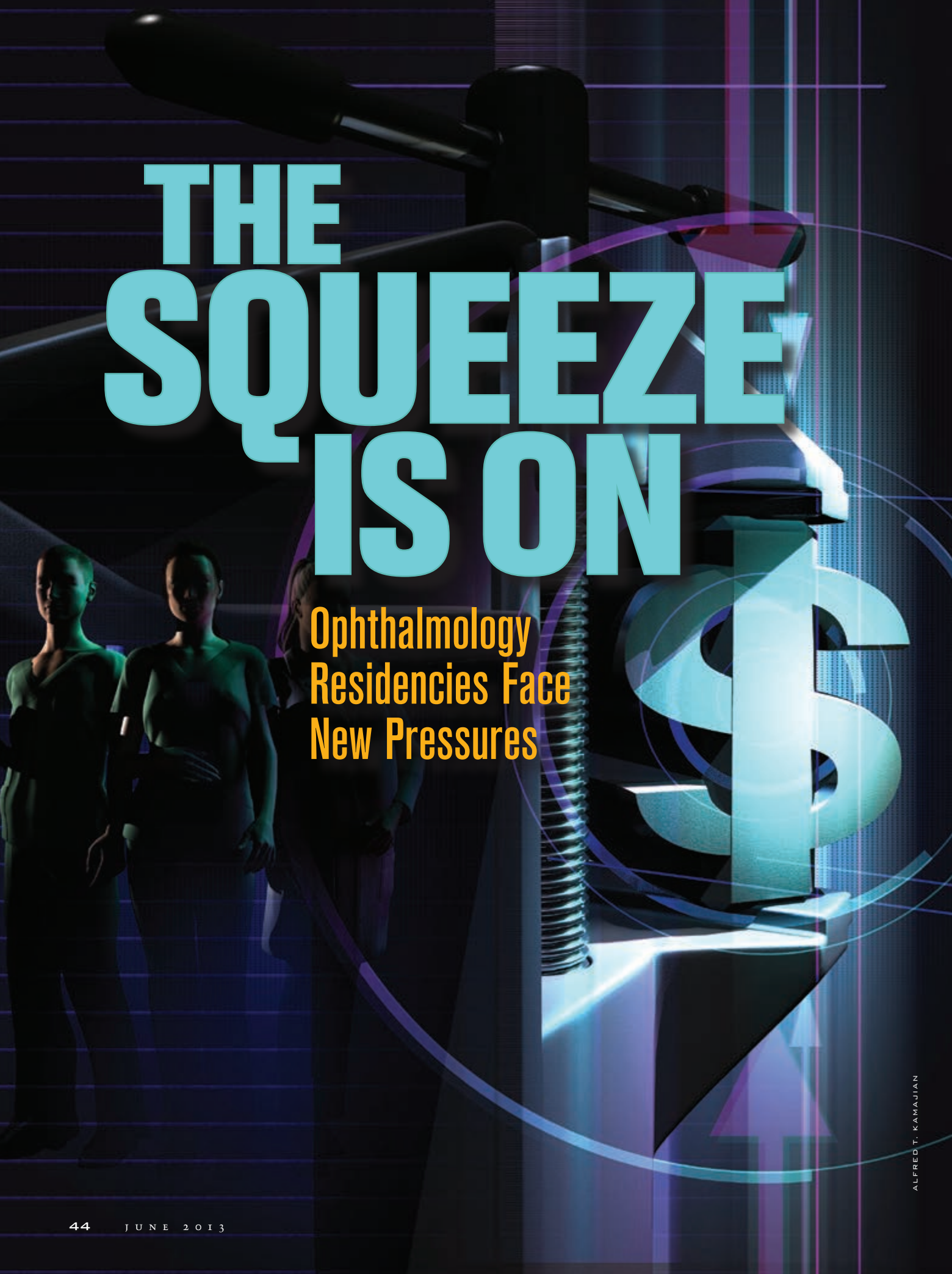
THE SQUEEZE IS ON

Ophthalmology Residencies Face New Pressures



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During the push-me-pull-you battles between Congress and the White House over the federal budget, most health care news coverage has focused on cuts to state and federal health agencies, reductions in research funding, and the 2 percent Medicare pay cut to physicians. But another area of medicine—graduate medical education (GME)—also stands to get squeezed by the automatic cuts known as sequestration.

GME is at a crossroads. Residency program directors are under pressure to do more with less, and budget cuts on the table call for reducing the amount that the government provides to GME, beginning in 2014. "No one's really going to bat for GME," said Geoffrey Broocker, MD, professor of ophthalmology at Emory Eye Center and associate chief of service at Grady Memorial Hospital in Atlanta. "We're sort of the last in line, as usual. It's horrific to think that we'd close training programs and reduce or eliminate care to the safety net hospitals."

For medicine in general, the timing couldn't be worse: Medical schools are graduating ever-increasing numbers of students, but the total number of residency slots has been capped at 1996 levels. Will there be enough residency slots to absorb all of the newly minted MDs?

For ophthalmology in particular, the situation is even more precarious. Not only is the number of residency positions virtually unchanged since 2003,[1] but the profession is also in danger of losing residency slots to other areas of medicine, particularly primary care.

The Big Squeeze

Ophthalmic educators across the country "are all wincing," anticipating deep cuts to their programs, said Dr. Broocker. "It's like when you had to get a flu shot as a child, and you sat there waiting for the pain."

"This is a very uneasy time," said Susan H. Day, MD, chair and program director for the department of ophthalmology at California Pacific Medical Center in San Francisco. "The costs of education are going up at the same time that we're being asked to trim our sails. Many new rules and regulations carry a price tag—so here we are, needing to meet standards that cost more money. At the same time, we have this cloud of uncertainty hanging over us. It impacts, very directly, our ability to provide care and educate physicians."

Medical school enrollments are on the upswing, but residency slots are frozen—and ophthalmology may lose some of its existing slots to primary care. The funding crunch in graduate medical education means reconsidering priorities and making tough choices.

BY JEAN SHAW,
CONTRIBUTING WRITER

A number of factors contribute to the increasing pressures, including the following.

Fewer dollars. "The basic problem is that the vast majority of dollars for GME comes through CMS," said Mark S. Juzych, MD, MHSA, chairman and professor of ophthalmology and former associate dean of GME at Wayne State University and director of the Kresge Eye Institute in Detroit. Medicare provides $9.5 billion annually, and the Department of Veterans Affairs (VA) and Medicaid provide another $2 billion each year. In addition, residency programs in a handful of states receive funding via Blue Cross and Blue Shield, Dr. Juzych said.

With regard to the Medicare funds, roughly two-thirds of that (about $6.5 billion) is an indirect medical education (IME) adjustment that goes to teaching hospitals to cover added patient care costs associated with training. The FY 2013 budget calls for the IME adjustment to be cut by $9.7 billion over 10 years, beginning in 2014.

Many residency programs also receive funds from their home institution. For instance, "We receive about 75 percent of our funds from the government; the rest comes from the hospital," said Thomas A. Oetting, MD, professor of clinical ophthalmology and residency program director at the University of Iowa. In his program, heightened fiscal awareness means that

"we're taking it upon ourselves to squeeze out any inefficiencies." Moreover, because Iowa's ophthalmology department already self-funds fellowships, "adding residency positions would be very hard," Dr. Oetting said. The bottom line, he said, is that "the cost [of increasing the number of residents] would fall on the hospital, not on the government. As a result, we'd have to justify why that's fair to the hospital."

Even relatively wealthy institutions are holding the line on GME funding. "Emory is one of the institutions that has a large endowment, but with GME, it's expected that we provide financial resources subsidized through our billing care of patients, even in indigent care settings," said Dr. Broocker. "There is no pot of gold waiting for us."

Hands-on learning. Resident at University of Illinois, Chicago, administers fluorescein.

In addition, the money provided by CMS and the VA now comes with more strings attached. For example, "the VA is getting pickier" about how it calculates resident work hours, Dr. Oetting said. Dr. Broocker added, "We can only bill for patient care delivered by residents if we attest to direct oversight in the evaluation and plan."

Given the current fiscal climate, the push for accountability will only increase. Several years ago, one of the administrators at Grady Memorial told Dr. Broocker that the hospital loses $2,000 a year on every resident. As Dr. Broocker noted, "Even with all of the directs and indirects coming in, where's the actuarial account of the dollars?"

Frozen numbers. The number of residency slots was frozen at 1996 levels by the Balanced Budget Act of 1997. For individual institutions, "There has been some leeway with these over the years as hospitals have closed, and slots have been distributed out," said Dr. Juzych. In addition, the VA has been able to add a few slots. Overall, however, these steps have been incremental and haven't had much of an effect, he said. "There has been some lobbying to open up the cap, but the government has been nonresponsive."

Since 1997, many hospitals have coped with the freeze by operating "over the cap." For instance, a hospital might have 1,000 official slots but be functioning with 1,100 residents. Those days are effectively over. "There is more pressure now to hold the line," Dr. Juzych said, and hospitals are going back to review their balance sheets and rethink their residency allocations.

More medical students. At the same time, an influx of medical students is on the way. In 2002, there were approximately 16,488 first-year medical students; by 2016, that number is expected to increase to 21,376.[2]

"The real squeeze is on the medical school graduates," said Dr. Oetting. "There's a wave of increase in the number of students but no increase in the number of residency positions. Here in Iowa, we realize that another ophthalmology residency position would be a good thing, but we don't see how we can fund it. We're on hold."

Workforce Issues

To add to the mix, battles over GME funding are running headlong into overall workforce considerations.

Demographics. The physician supply is expected to increase by 7 percent in the next decade. At the same time, the number of Americans over the age of 65 is expected to increase by 36 percent.[3] Moreover, presuming that the Affordable Care Act is not overturned by Congress, millions more individuals will enter the health care system as a result of expanded insurance coverage.

Overall, the shortage of physicians across all specialties is expected to increase from 62,900 physicians in 2015 to a shortage of 91,500 physicians in 2020. The deficit in physicians providing specialty care is expected to increase from 33,100 in 2015 to 46,100 in 2020.[3]

Push for primary care. Ophthalmology is at "particular risk" at this time, said Dr. Day. "The conventional funding for GME goes to institutions for a total number of slots that are not allocated to individual specialties. Those slots can be used for whatever the hospital deems to be necessary or appropriate."

As hospital administrators review their residency slots, the concern for ophthalmology is that it is not seen as being "mission critical," Dr. Juzych said. "My big fear is that ophthalmology slots will be reallocated to other

specialties, such as general surgery and family medicine."

Dr. Juzych has plenty of company, said Dr. Oetting. "This is a different landscape. A lot of us are concerned that when the hospitals look to see how much value various positions add, ophthalmology may be seen as less essential."

To date, Medicare's GME funding has not come with any particular requirements to encourage residents to become primary care physicians. (Some analysts have suggested redirecting GME funds to the training of nurse practitioners and physician assistants, and the FY 2013 budget includes a slight expansion in the funds for training these providers.[4]) But the fear that ophthalmology may lose residency positions to primary care is well-founded. "I've been told by several program directors that they have been approached to trim their numbers so that the sponsoring institution can redistribute slots," Dr. Day said.

Eye care needs. Ironically, this threat to ophthalmology training positions is coming at the same time that the prevalence of age-related macular degeneration, glaucoma, cataract, and other eye diseases is rising with the overall aging of the U.S. population.

"From the GME standpoint, we have always done our job based on educational capability," said Dr. Broocker. "That is, do the patient volume and different types of patient pathologies provide a broad enough curriculum for our residents? That's the bottom line on justifying the existence of a program."

Theoretically, from the perspective of workforce requirements, the expected increase in eye diseases should help ophthalmology programs defend their residency slots. "If you just consider patients with diabetes, it takes an annual eye exam to adequately care for them. The hard truth is that we don't have enough ophthalmologists to do that—so it's possible that making the workforce argument would help," said Richard K. Parrish II, MD, associate dean for GME and professor of ophthalmology at the University of Miami.

However, Dr. Juzych cautioned, "Right now, that argument isn't getting any traction." Ophthalmologists understand its importance, "but no one's complaining, so it really doesn't have an impact."

Potential Solutions

Dr. Day, who sits on a state subcommittee for the California Hospital Association, notes that "there is no eminently clear possibility" that will make up for shrinking federal funds. Nonetheless, a number of options are under consideration across the country, including the following.

Industry support. If you're going to think outside of the box, should you consider turning to the pharmaceutical or medical device industry? Galderma Laboratories has pledged

Capitol Hill Update

Two pieces of legislation on GME were introduced in mid-March.

- **H.R.1201: "Training Tomorrow's Doctors Today Act,"** cosponsored by Representatives Aaron Schock (R-Ill.) and Allyson Schwartz (D-Pa.).
- **S.577: "Resident Physician Shortage Reduction Act of 2013,"** cosponsored by Senators Bill Nelson (D-Fla.), Harry Reid (D-Nev.), and Charles Schumer (D-N.Y.).

These bills have several points in common:

- They would create 15,000 new GME slots around the country over a five-year period.
- They require studies to identify physician shortages in various specialties and to boost workforce diversity.
- Half of the new residency slots are to be set aside for "shortage specialty residency programs."
- No hospital could receive more than 75 of the added slots in any fiscal year (S.577 includes an exception for years in which CMS determines that remaining slots are available for distribution).
- The House bill also calls for increased financial transparency, requiring teaching hospitals to report the full cost of their medical residency programs, including the cost of a medical resident's laboratory and research training.

Taking a stand. Medical students converged on the Capitol in February to advocate for GME.

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$450,000 to help support the dermatology residency program at Baylor University Medical Center in Dallas. Could something like that happen in ophthalmology? "That's a billion-dollar question," Dr. Juzych said. "Clearly, it raises some very controversial issues." Given the current regulatory climate, Dr. Broocker doesn't consider it to be a feasible approach. "We would be slapped on the hand by governmental and institutional regulations if we tried to work with private industry."

Insurance companies. One much-discussed option includes having insurance companies shoulder some portion of the funding. "In the 1990s, certain insurance companies participated in GME funding," Dr. Broocker said. "At the time, that looked like a feasible strategy, but it has taken a turn for the worse."

"It would be nice to think that some private insurance company would step in, but I don't see that happening," Dr. Oetting said.

Legislation. "There's no new money at this particular point in time, and policymakers recognize it," said Dr. Juzych. Even so, it's possible that relief will come via legislation. Two bills were introduced in Congress—one each in the House and Senate—on March 14 (see "Capitol Hill Update").

Philanthropy. "Many programs are looking at philanthropy," Dr. Day said. Historically, however, "philanthropy has had a difficult time raising money for education. It has done better at funding clinical and basic research." Dr. Broocker added, "When it comes to GME, institutional and departmental efforts have been limited."

Salaries and billing. One option that has been bandied about is to pay residents less—or even to not pay them at all, Dr. Oetting noted. Some fellowships are already structured in that way, he said. And Dr. Juzych noted that a congressman representing Michigan in Washington, D.C., proposed that residents begin paying tuition. "That's basically indentured servitude." Another potential option would have residents bill directly as a means to supplement their salary, "as in the real world," said Dr. Broocker. But, he added, that is not possible as long as their training is tied into CMS pass-through funding.

The art of observation. Residents at the University of Iowa hone their examination skills.

Revised fellowship funding. Another strategy involves advocating for a change in the way accredited fellowships are funded. Currently, these, too, are in large part paid for by CMS. "This is not applicable to ophthalmology in the sense that the specialty, with the exception of oculoplastics, has no ACGME [Accreditation Council for GME]-accredited pathway for fellowships," Dr. Day said. Even so, "If, for example, there were a change to allow accredited fellowships to have a different funding mechanism, that would allow a greater number of capped slots to be used on primary certificate or specialty training," she said.

The Advocacy Challenge

"Academic medicine has a limited advocacy voice," Dr. Day said. ACGME is the major accrediting body, but it does not have an advocacy role; funding is "not within its scope," she said.

As for the American Medical Association (AMA) and the American Association of Medical Colleges (AAMC), both groups have spearheaded efforts to preserve GME funding. Overall, however, they have "advocacy domains far beyond GME," Dr. Day noted.

Once again, the onus is on physicians—whether they are still in training or in practice—to make themselves heard. At the moment, "GME funding is not high on anyone's agenda but our own," said Dr. Broocker. He argued that medical students may make particularly good advocates. "This may be a restraint of trade issue, and these are the people who are being directly affected."

As for practicing ophthalmologists, "It's up to us to prove that ophthalmology is a critical component" within the hospital setting, Dr. Juzych said.

It's also possible that the push for electronic health records (EHR) could be used to help

make the case for ophthalmology, Dr. Parrish said. "There's a pragmatic perspective: If eye care needs to be done, it needs to be done. If we don't do it, we can't expect primary care doctors to determine whether a patient has early AMD or glaucoma. As medicine becomes more integrated via EHR, ophthalmology needs to become part of that."

In the interim, the newly introduced legislation offers physicians another avenue. "If your senator is on the Senate Finance Committee, then contact him or her so that these measures continue to be discussed in committee and not just tossed aside," said Dr. Parrish. (To find contact information for your federal legislators, along with a list of their committees, go to www.aao.org/advocacy and select "Contact Your Legislator.")

Final Thoughts

"There will be some solution because it's essential that we have physicians—but how we'll get to that point is anybody's guess," Dr. Day said.

She added, "The average politician doesn't realize the cost of teaching—or, especially, the value that this has for society. Residents provide a tremendous benefit to patients, serving as a second or third ear. They have a terrific track record of being empathetic and of spending time with patients."

The average citizen is equally unaware of the issues involved, said Dr. Parrish. "Most people don't even understand that trainees are paid via federal tax dollars. And, if you look at the safety net hospitals, even though residents are of tremendous value there and provide much of the care, people don't see that as a priority."

"I've been working with residents since the mid-1980s," Dr. Broocker said. "If you want a best buy in health care, residents are it. These young, energetic individuals are willing to work arduously in difficult environments; they take a lot of grief for the least amount of pay; and they're an absolute joy to work with. The only problem is that they stay the same age and I get older." ■

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