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Review Article

Graduate Medical Education and University Physician Specialist Training in Nevada

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Abstract

Graduate medical education funding in the United States is the key to training specialists in healthcare in Nevada. Providing stable funding to the system ensures residents will remain in the communities they reside when their undergraduate medical education is completed and followed up with Graduate Medical Education. In Nevada 77% of physicians who complete both undergraduate and graduate course work in the states remain in the state. From 2021 to 2023 there were a total of 389 residents who pursued residencies from the University of Nevada Las Vegas and the University of Nevada Reno. 98 students stayed in Nevada and 70 of those students graduated from UNLV. In order to grow the workforce Nevada needs to train specialists in the communities where they train. Medical specialists like dermatology typically choose to stay in the communities where they receive their training. In order to grow a medical workforce teaching hospitals and purposeful cooperative collaboration is needed to provide adequate funding to train physicians who will practice in Nevada.

Keywords: American; Allopath; Disciplines; Education; Global Healthcare Systems; Graduate; Match day; Medicaid; Medical; Medical Residency; Medicare; Nevada; Oral Surgeon; Osteopathic; Physician; Physician Shortage; Prevention in Primary Care; Programs; Specialty Treatment; Undergraduate; University of Nevada Las Vegas (UNLV); University of Nevada Reno (UNR)

Introduction

[1] December 18, 2023 the Centers for Medicare and Medicaid Services (CMS) published the list of 200 Graduate Medical Education (GME) slots awarded in the second round of distribution under Section 126 of the Consolidated Appropriation Act of 2021. 229 hospitals applied and 99 were awarded funding. In round two, Nevada was awarded 4.34 slots for Indirect graduate medical education (IME) 2.41 to Renown Regional Medical Center for Pediatrics and 1.93 to University Medical Center of Southern Nevada for Internal Medicine (UMC). No Direct Graduate Medical Education (DGME) was awarded to Nevada. The average DGME awarded was 2.02. Nevada was the only state that was awarded IME, but no DGME funds. Nevada is one of four states whose Medicare Administrative Contractor was administered by Noridian.

[2] In order to be awarded slots, Section 126 required hospitals to qualify in at least one of four categories listed below and mandated that at least 10 percent of the cap slots would go to hospitals in each category.

- Hospitals in rural areas (or treated as being located in a rural area under the law)
- Hospitals training a number of residents in excess of their GME cap

- Hospitals in states with new medical schools or branch campuses
- Hospitals that serve areas designated as health professional shortage areas (HPSAs)

This fourth eligibility category refers only to geographic HPSAs and not population HPSAs.

[3] According to the American Medical Association (AMA) the 1,000 new Medicare-supported GME slots included in the $2.3 trillion Consolidated Appropriations Act of 2021 was much needed, but details regarding the allocation of those residency positions were included in the 2022 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals final rule published by the Centers for Medicare and Medicaid Services (CMS). The final rule with comment period builds off the April 2021 Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) [4]. The 2025 IPPS rule distributes GME residency slots under section 4122 of the Consolidated Appropriation Act (CAA), 2023. Requiring the distribution of an additional 200 Medicare-funded residency slots to train physicians. This is consistent with the Biden-Harris Administration's Unity Agenda, and focus on tackling the mental health crisis, this provision dedicates at least one-half of the total number of positions to psychiatry or psychiatry subspecialty residencies. The law requires CMS to notify hospitals receiving residency positions under section 4122 by January 31, 2026. In order to meet that deadline, CMS is proposing to implement policies that will govern the application and award process in a manner consistent with the statutory requirements. CMS is also proposing, to the extent slots are available, to focus on health professional shortage areas to help bolster the healthcare workforce in rural and underserved areas. CMS estimates that this additional funding will total approximately $74 million from FY 2026 through FY 2036.

All of these efforts are good for the country, but it is not enough. The state of Nevada is in a severe healthcare crisis and residents are not being adequately compensated. While nationally the pay of $59,000 seems adequate it is currently below what is considered a living wage $104,000 in the United States. The extreme shortage of physician and residency programs needs to be resolved by eliminating the GME caps on funding to solve the shortage of healthcare professionals. Not only should we pay residents a living wage we need to allow states who have just now become able to train their medical workforce to compete with states that have been training for centuries. Nevada requires a drastic increase in GME residency slots. A possible compromise to lifting the caps for all states would be to lift the caps for states who have newer schools of medicine, or to lift caps for those states who do not currently meet the national standard.

The purpose of this paper is to encourage original research in the area of Graduate Medical Education in Nevada, and encourage purposeful cooperative collaboration between for profit, nonprofit, higher education, and government entities to create a stable pipeline of students to provide high quality healthcare for Nevadans. A literature review was conducted using the University of Nevada Las Vegas Library, Google Scholar, and search engines to scour information digitally. Search terms used were graduate medical education in America, graduate medical education in Nevada, tier one research institutions, teaching hospitals, allopathic medicine, osteopathic medicine, physician shortage, global healthcare systems, dermatology, oral maxillofacial surgery, and the role of government in physician training.

Discussion

[5] In order to meet the standards of the federal government Nevada needs an additional 2,561 physicians in the healthcare workforce [6]. The Nevada Independent reported that while the physician numbers are on the rise, Nevada is well below the national average [7]. The state needs 1,038 physicians in medical specialties, 540 surgeons, and many other physicians in other specialties. While the majority of the population lives in Las Vegas and Reno there are many rural areas who are experiencing even greater health disparities because of the lack of adequate healthcare. Not only is the state short on physicians those who are in the workforce now are approaching retirement and 17% of licensed doctors are inactive. The average age in some counties of the state is 61.2 for allopathic and 49.7 for osteopathic physicians [8]. To make matters worse many of the physicians who leave to train elsewhere end up establishing residency within 100 miles of the residency program.

Currently, Nevada does not have residencies at their R1 research institutions for dermatology, ophthalmology, neurosurgery, urology, hematology/oncology, and rheumatology. Being one of the sunniest states in America it stands to reason Nevada would have a dermatology residency in the schools of medicine. An academic

teaching hospital with fully funded GME slots in all specialties is needed if Nevada is going to bring the healthcare workforce up to national standards. Currently, the Kirk Kerkorian School of Medicine at the University of Nevada Las Vegas (UNLV) and the University of Nevada Reno School of Medicine (UNR) do not have teaching hospitals. Because they do not run teaching hospitals they do not receive GME funding. UNLV does have a School of Dental Medicine, but they do not train oral maxillofacial surgeons.

GME is primarily funded through Medicare and Medicaid. Additionally, other funding sources include private payers, the Health Resources and Services Administration (HRSA) which funds GME in children's hospitals and community health centers, the Veterans Health Administration, and the Department of Defense. There is an opportunity for research to be done on how the federal agencies could partner with Universities to train the physician workforce. Medicare, Medicaid, HRSA, the department of defense, and the Veterans Administration need a mechanism to provide funding to their local partners like universities to train the physician workforce.

[9] Now that the workforce is no longer bound by geography we are seeing a rapid growth in rural populations in the western United States and have been since 1970. Factors that are driving this growth are tourism, recreation, resource development, manufacturing, commuting, institutional employment, and retirement [10]. Las Vegas in recent years has become an international destination and the tourism industry in 2023 had a total economic impact of $85.2 billion. Not only is the tourism industry growing but the state is diversifying their economy to better weather economic downturns. Tonopah [11]. Nevada just found one of the largest lithium deposits in the United States. In October 2022 the American Battery Technology Company received a federal grant of $57 million as part of the Bipartisan Infrastructure Law to design, construct, commission and operate a $115M commercial-scale facility to demonstrate ABTC's novel process for the manufacturing of battery grade lithium hydroxide monohydrate from Nevada-based lithium-bearing sedimentary resources. This find will bring 50 to 125 jobs during construction and another 50 once the construction is complete.

[12] There is no doubt there is a need to reform. Some argue that continued support should be contingent on GME's demonstrated value and contribution to the nation's health care needs. Unquestionably the many years of federal support established the GME system as a model for training high quality physicians [13]. Often the debate focuses on the GME as a national solution and we miss the role that states play in GME. In Nevada the Office of Science, Innovation and Technology manages state GME funds, however the states resources are limited and they have not been able to fund enough positions to bring the state up to national standards [14]. In order to improve GME funding creative solutions are needed to diversify GME funding and improve resident compensation [15]. Purposeful cooperative collaboration is needed in order to improve GME.

Conclusion

In the 1990's it was believed that there was a surplus of 200,000 physician in the workforce. Because of this belief the United States Congress imposed a cap on how much the federal government spends on funding physician graduate medical education. The available GME slots have not kept pace with the population growth especial in the Mountain West. Nevada like many western states needs to have those caps lifted, so they can train physicians who will stay in the state, in order to solve their physician crisis. Because GME is awarded to hospitals it would help if federal funds could be used to build teaching hospitals at the states two R1 research institutions. Building the hospitals and fully funding GME programs, in order to, train the workforce to meet the needs of the burgeoning population, will result in equity among their medical peers. Many bills have gone through congress calling for the removal of the CAPS and during the Covid-19 relief package 1,000 new residency slots were prioritized, but even if every one of those slots was allocated to Nevada it is not enough to bring them in line with national standards.

The University of Nevada Las Vegas and the University of Nevada Reno have partnerships with other hospitals, but would benefit greatly from having their own teaching hospitals where they could train students in all medical specialties. It would be most effective to lift the caps on GME, and send the appropriate funds to the respective programs so they can train up the healthcare workforce in Nevada to meet national standards for employing physicians in their respective communities. Both UNLV and UNR are flagship universities in the state of Nevada with extraordinary visions for the future of the state. These leading research institutions have a

significant impact on their respective economies. They are poised to train the future workforce, if the barriers congress established are removed, so they can compete with their peers nationally. Nevada deserves to have locally trained dermatologists and oral surgeons, but they cannot do it without adequate funding. If local government, state government, the federal government, private for profit, and not for profit companies purposefully cooperative collaborate they can find solutions to the training. Each group has a role to play to benefit the community so Nevada can have a pipeline of healthcare professionals that stay in the state to treat patients.

Utilizing the existing structure of the Nevada System of Higher education and the relationships that exist between the community colleges, state college, and research institutions there is an opportunity to train a workforce that can benefit both the urban and rural communities in the state.

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