GME Funding
Financial Implications of Curriculum Design

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- None
- No Off-Label Disclosures

(Though our residency programs are funded by almost every source we are going to talk about...)
Learning Objectives

• Describe the process of funding GME programs including the GME “cap”, indirect, and direct GME funds flow and non-traditional funding sources.
• Discuss the financial implications curriculum decisions for residency programs.
• Review the budget discussion that allows a program to justify the size of the resident work force.
• List three things your program can do to prepare for future GME funding changes.
To understand the future…
…you need some historical perspective
History of GME funding

1965 – Social Security Act created including Medicare, Medicaid & Graduate Medical Education (GME) funding.

Why?

“Education improves quality of care, and should be an element in the cost of care to be borne partially by the hospital insurance program, until the community bears the cost in some other way.”
History of GME funding

• 1980’s – Reform of GME payments
  • Direct costs (DME or Direct GME)
  • Indirect costs (IME)

• GME funding became the primary source of hospital-based indigent care & teaching hospitals/residents became the soul source of care for poor populations.
  • Disproportionate Share Hospital (DSH) funds
Historical Financing of GME

- CMS Medicare/Medicaid funding
- State Medicaid funding
- State indigent care monies
- Hospital/patient care funding
- Research & education stipends
- Private funding (Blue Cross, Institutions, Practice groups)

Residency Program funding
History of GME Funding

• 1994 – Full funding limited to the time of training for Initial Residency Period (IRP) per resident. More time is reimbursed as 50% DME (100% IME)

• First residency started sets # of years of funding
  • Applicant starts in IM program > IRP = 3 years
  • Applicant starts in Surgery program > IRP = 5 years
• Fellowship after residency – all pass IRP
History of GME Funding

• 1997 – “Cap” applied to the Intern & Resident per Bed ratio (IRB) at each hospital.
• “Over the cap” = employ more residents than funded slots

• Cap halted development of residency programs for years

In practical terms…

• “Over cap” means we have more employed residents than we have slots.

• No one program is “over cap”, adding residents just reduces the per resident subsidy.
How do we count residents?

<table>
<thead>
<tr>
<th>Number of Accredited Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Employed Residents (what the hospital is paying for)</td>
</tr>
<tr>
<td>Residents on the CMS Cost Report</td>
</tr>
<tr>
<td>The “CAP”</td>
</tr>
</tbody>
</table>
Why be over cap?

- Some subsidy is better than no subsidy (no other workforce element is subsidized)

- Residents are attractive (attract faculty, provide marketing value, facilitate service lines)

- They work more than the “usual FTE”, some time twice as much (up to 80 hours)
Direct GME

- Direct GME stipulations
  - Pays for all time residents spend at a hospital & “non-provider setting” when they are “primarily engaged in furnishing patient care” & didactics
  - Pays for vacation & leave that do not prolong resident’s training
    - If the hospital pays for:
      - “Substantially all” (90%) of the cost of the salary & benefits of the resident
        - Away rotations (some)
      - The appropriate portion of the teaching faculty salary & benefits
Calculating Direct GME (DME)

Per Resident Amount (PRA) set in 1984 – 1985

- Increases based on consumer price index
  - Cost of GME training has increased substantially more than CPI over the past 20 years
  - For the past several years, only primary care receive CPI increase, so now primary care & specialty residents are funded at different amounts.

To calculate –

PRA $100,000 x 100 residents x 35% inpt Medicare beds = $3,500,000
Two types of payments – Indirect GME

- Indirect GME...a misnomer
  - Actually used for indirect *patient costs* related to having a GME program and operating costs
  - Intended to pay for more complex patients, standby capacity for trauma/burn centers, & learner inefficiencies such as increased length of stay

- Things not paid for:
  - Time spent in medical school setting without a hospital (if your simulation lab or conference room is there) or away conferences for 1 day or more
  - Time spent on international rotations
    - No Medicare beneficiaries overseas to care for
Calculating the IME

• Formula to calculate IME:

Adjusted ratio = IME multiplier\([1 + (\#\text{residents}/\#\text{beds})]^{0.405} - 1\]

IME adjustment = Adjusted ratio x (%Medicare pts.)(DRG payment) (Case mix ratio)

• Since 2003 IME Adjustment = 1.35, so 5.5% increase in DRG payment for every 10 resident increase/100 beds
Medicaid GME

- Medicare GME (2012 - $10 billion)
  - DGME & IME together

- State Medicaid GME (2012 - $3.8 billion)
  - Part of funding goes to the state from CMS
  - States can match this & some do up to 50%
  - Some states have a separate indigent care fund from their own state monies that help fund urban teaching centers
GME funding for Fellowships

- ACGME approved fellowships
  - Fellows are treated as residents for DME & IME
  - Since they are training longer than their initial residency period, they count as 0.5 FTE
  - Can’t bill Medicare for DME/IME for fellows & bill Medicare for use of them as an attending
  - Can bill for something outside their field – Toxicology, Hyperbarics vs. working as an attending in the ED

- Non-ACGME fellowships
  - Cannot get DME & IME, so they can bill attending rates
    - Typical fellowship requires 80 hours/month clinical time
GME Funding Summary

Questions?

"Graduate Medical Education That Meets the Nation's Health Needs."
Program Decisions

...often have an expense
Program expenses

• Running a program can be expensive…and it should be. Many expenses are fixed. As an example…
  • Salary, benefits, liability insurance
  • Accreditation fees, in-training exam
  • Program coordinator
  • Licenses, background checks, lab coats, scrubs
• When your institutions decides that they will sponsor your program…they agree to these expenses
Program expenses

- Meets an explicit accreditation requirement
  - “Residents must spend one month on…”

- Meets an explicit but not define requirement
  - “Residents must be trained in…”

- Usual and customary: “all programs do this”

- “Makes my program unique” “I need this to recruit”, “We’ve always done it this way”
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Rotations to watch (paid or not?)

- Administrative months
- Research experiences: longitudinal versus discrete assignments
- QA/QI/PS months
- Out of the hospital rotations assignments
  - Receiving hospital returns GME money
  - Receiving hospital does not return GME money
  - Receiving hospital demands money
- Electives
  - “in-house”, “away”
Out rotations

- Review “out” rotations (Home hospital is paying the resident’s salary, resident working elsewhere)
  - Required to meet accreditation standard
    - Hospital reimbursed
    - No money exchanged
    - Hospital pays
  - Required to meet curriculum need
    - Hospital reimbursed
    - No money exchanged
    - Hospital pays
- Electives

How many FTEs per year does your program need to support out rotations?
Maximizing CMS funding globally

- Only match residents who have no prior training
- Move rotations to hospital w/ higher PRA for DME
- Move rotations to hospital with higher % Medicare patients
- Move rotations to hospital with DSH funding (minimal now & always on the chopping block)
- Don’t allow international rotations if close to cap
What might be “lost” for these rotations?

12 residents/class, 1 away assignment/month for each of 3 years for “non-required” rotations

- 36 months annually = 3 FTE = ~ $300,000 cannot be claimed but expense is incurred
- Assuming one of the rotations is with a private practice faculty who would like to be paid FMV for lost productivity and non-clinical activities related to the resident (such as orientation, evaluation, discussion) ~ $100,000
- 36 months of lost “service” requires 3.5 FTE of replacement staff ~ $300,000
Supervision models
Supervision can be expensive

• Direct $$$ > indirect $$ > oversight $

• Are your residents working in a “levered” model?
  • Do the residents enhance faculty productivity?
  • Do the residents erode faculty productivity?
  • Do you even know?

• What does your operational scheme look like?
  Supervision is embedded in your operations.
Which is more expensive?

Attending

PGY 3

PGY 1

PGY 2

PGY 1
Which is more expensive?

Attending

- PGY 3
- PGY 2
- PGY 1

- PGY 1
- PGY 1
Which is more expensive?
Which is more expensive?

SAFETY vs PRODUCTIVITY vs TRAINING

- Attending
- PGY 3
- PGY 1
- PGY 2
- PGY 1
- PGY 1
Resident Assignments

• Poorly skilled junior trainees in high volume areas? Highly skilled residents in high volume areas?

• Senior residents “learning” to supervise? Is this a productive use of their skills and competency?

• Junior residents assigned to decision making bottlenecks?
  • Deciding who is admitted?
  • Deciding who is discharged?
Other “discretionary” expenses

- Number of core faculty…in addition to making your scholarly activity “denominator” larger, you may also be spending more money on teaching dollars

- Faculty conference attendance: how many do you need?
  - If you had 200 hours of conference a year and each faculty attend 20 percent of all conference (40 annual hours) and you had 10 core faculty…
  - 400 hours of teaching time to be paid for
  - 400 hours of lost clinical productivity
- True for any non-clinical faculty activity: PEC, CCC, recruiting, as examples
Decision related to residents

- Residents on extended training
  - Extend a resident by 6 months....that’s a $50K decision

- Residents on H1B visas
  - Mandated governmental fees, attorney fees, expedited processing, visa renewals, # of LCA sites

- Residents past their Initial Residency Period (IRP)
  - Set when resident begins training, does not change
  - DME reimbursed at only 50% if the resident exceeds IRP (all capped at 5 years), IME reimbursed at 100%, exceptions for geriatrics, pediatric neurology, preventative medicine

- How many residents do I “need”?
“Right” size the programs

- Do some programs need more residents? Do some need less?
- Hospital CEO, “I noticed we have fewer patient days each year, why do we still have the same number of medicine residents?”
- “Can you bring me a list of the “over cap” residents and “over cap programs”?
- This is complicated and needs a broader workforce discussion with administration
How many caregivers do you need?

- MLP
- Residents
- Attendings
Right size the programs

- Review number of trainees per program
  - Has changing clinical environment shifted workforce need? Reduced admissions, increased outpatient…
  - Expanding service line? Contracting service line?

- Residents are subsidized and efficient (salary less than MLP, works 1.5-2.0 “normal” FTE)...but why have more than we need?
Cost controls the DIO might consider?

- Internal cap adjustment to eliminate high cost/low value programs and grow others
- Centralize GME costs to improve efficiency
- Stagnate resident salaries...until they pay tuition (happens now for dental specialties)
- Differential salaries for programs (popular...pay less/critical...pay more)
- Eliminate resident perks (not required by accreditation requirements)
- Reduce teaching dollar payments to departments
Program decisions

...might add revenue
Add more revenue or more slots?

- Charge medical schools for clerkship
- Private industry
- Third party foreign support
- Rural hospitals support
- Underserved out-patient facilities
- VA GME slots
- Seek redistributed cap slots
- Grow new positions in virgin hospitals...then aggregate
- Acquire other teaching hospitals and aggregate
- Pray for a legislative miracle
Charge medical schools

• You provide a value commodity…you (and hospitals like yours) provide 3rd and 4th year education to medical students

• They are charging tuition…so you can teach

• “What would happen if we took the medical students out tomorrow?”… “We would take out expense”
Private industry

- Device manufactures
- Pharmaceutical companies
- Contract management groups
Third Party Foreign support

• This is happening now

• Some programs set aside positions for these “fully funded residents”

• Programs create “tracks” to comply with NRMP “all in” policy…submit two ROL

• Might be able to increase resident cohort and provide additional resources for the program (time and money)
Rural community/gov’t support

- CMS rural residency – 50% of program must be rural
- VA initiatives, rural hospital initiatives

- For example…a small town needs a cardiologist
  - Incentivize the physician
  - Incentivize the hospital
VA GME funding

- VA is the 2nd largest provider of GME funding in US
- Provides DME/IME for 9,500 residents nationally (~9%)
- New GME funded positions offered over next 5 yrs

- Generally pays training institution DME ($84,000)
- VERA - Veterans Equitable Resource Allocation pays VA indirect costs (passed on?)
- Negotiated thru Education Cost Contract
Underserved Out-patient Facilities

• Federally Qualified Health Centers (FQHC) receive higher than normal Medicare reimbursement
  • Determine how to make faculty more productive with resident involvement

• Teaching Health Center GME (THCGME) grants

• Allows GME funding at FQHC & FQHC look-alikes for primary care resident training & dentists
  • Currently HRSA not authorized for enough funds
Seek redistributed slots

- When hospitals closed, their GME slots evaporated in the old days

- Now when hospitals close, the slots can be redistributed through a “5506 redistribution”
  - Complex rubric for priority ranking
  - Application made to CMS
  - CMS determines redistribution
  - You need to be located in the closed hospital’s CBSA
Grow GME in virgin hospitals

- Virgin hospitals (~2000 nationally) = hospital that has never had GME trainees in the past
- Best to start primary program to determine PRA
  - PRA includes salary, space, infrastructure & regional norm
  - “Build a cap” – 5 year rolling aggregate
- Once cap mature, aggregate slots through affiliation
Acquire and aggregate

• Lots of rules here
• “Medicare GME affiliation agreement”
• “Common ownership” is generally required and can be complicated
• Sure wouldn’t be the reason to buy a hospital
Budget Matters
Tragedy of the commons
GME Office

• Centralize processes, cost share, economy of scale, buffer between programs and “administration”

• Work with programs on:
  • Out rotations
  • Elective rotations
  • Follow the money

• Help programs transition…win principled prioritization
Principled Priorities

• Don’t fight over money, fight over valued principles

• Meets clear, explicit accreditation requirement
• Meets general accreditation requirement
• Meets best practice curriculum element
• Meets desired program element

• Which budget model do you use?
Budget models

• Traditional
  • What did we spend last year? Was that enough? Even if it was (wasn’t) add 10%.
  • Add a buffer…you know “they” will cut it anyway. “They” know you are padding your budget
  • Positional bargaining versus principled negotiation

• “Zero-based” budgeting and budget scripts
  • Starts with “0” each year
  • Creates a sense of “fairness” and trust, especially if widely adopted in the institution.
What Does Everyone Else Think?
IOM Report – July 2014

Recommendations:

• Maintain Medicare funding for the next decade
  • Gradually move to outcomes-based payment system

• Develop more specific policy of financing the infrastructure
  • GME Center within CMS

• Have Transformational fund
  • Start with 10% innovation, then move towards national resident amount to follow resident
“…Residents bear the cost of their own training. [Therefore, consider] strategies that directly benefit the recipient physician instead of the training institution.”
What might change?

• Significant discussion going on in Washington
  • Current Administration proposal is 10%
    • Latest Republican budget even higher cut

• AAMC & health policy experts:
  • Move residency funding away from Medicare
  • Possibly give direct funding to each resident

• Reality – no public support to remain the same:
  • Average residents salary >50 %tile in US
  • Average practicing physician salary >95 %tile
This is GME...
Colliding issues

- Medical students, medical schools
- Advance practice providers
- Affordable care act...more insurance, more healthcare...worsening manpower issues

- MEDPAC recommend “performance based incentives” for GME
- IOM – GME should move to outcomes-based payment system

- Ongoing ACGME requirements
Make the “business case”

- Understand the C-Suite has different values than you…address their concerns…in their terms
- What is the ROI on your program?
- Know how much your program “costs”…everything included
- How do faculty perform with and without residents? Look at billing data
- Understand the faculty work caps are expensive compared with others…show faculty value
- “Zero based, scripted budgeting”
Questions?

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Summary

• Get in the game, it’s a brave new world

• Understand the business of medical education

• Engage in principled prioritization and negotiation

• Articulate your teaching effort, value it

• Express your value…in their terms