GME Funding

Now you see it… now you don’t. …inside baseball from the GME office

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Overview

- The “Cap”
- Direct and Indirect GME money
- Counting residents
- Financial pressures
  - Increase revenue
  - Decrease spending
- Teaching time pressure
- Valuing your residents
- Legislative issues

Historical Perspectives

- In 1997, Congress imposed a limit or “cap” on the amount they would reimburse for GME training, about $9.5 billion in Medicare, $2 billion in Medicaid
- The “cap” was determined by the residents counted in 1996
  - While the amount was derived by counting residents…what is capped is the money
- Other 3rd party payors “support GME, separate program for pediatric hospitals
- States also paid $3.78 billion Medicaid (much from federal money)
In practical terms...

- Training residents is primarily aimed at our mission as an academic institution.
- The residents and fellows are a subsidized workforce.
  - The absolute of subsidy is fixed (except for podiatry and dental).
  - When more trainees are added, the amount subsidized "per resident" is reduced.
In practical terms...

- "Over cap" means we have more employed residents than we have subsidy (more on counting residents)

- No one program is "over cap", adding residents just reduces the per resident subsidy

Other definitions

- "Accredited"
  - ACGME, AOA, CODA, CPME
  - "unaccredited programs" can have Medicare "funding"…they take care of Medicare patients

- 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
Initial Residency Period

- Suppose a medical student matches into Internal Medicine…their IRP is 3 years. Suppose after a year, they change their mind and want to become a surgeon… the IRP is still 3 years.

- As a surgical resident, 100% DME for only 2 years…50% DME for remaining 3 years.

Two types of payments

- Direct GME (intended to pay Medicare’s share of added costs to train residents)
  - Resident stipends and benefits
  - Teaching salaries and benefits
  - Costs related to maintaining GME infrastructure

- Payment uses your ("Per Resident Amount") x (Medicare utilization) x (resident count (cap))

- The PRA was set along time ago.

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
      - Must pay volunteer faculty something
Two types of payments

- Indirect GME... a misnomer
  - Has an "educational" label
  - 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, and learner inefficiencies

- IME adjustment $1.35x ((1 + IRB)^{0.405} - 1)

IME

- Indirect Medical Education adjustment
  - Increases each DRG paid by Medicare to the hospital by about 5.5% to make up for increased cost of being a training facility.
  - Decreased 28% over past 15 years

- Things not paid for:
  - Time spent in medical school setting without a hospital (if your simulation lab or conference room is there)
  - Time spent on international rotations
    - no Medicare beneficiaries overseas to care for

Resident Research Time

- Direct GME – Research not having to do with direct patient care will be funded if done at the hospital, but not at a non-hospital setting.

- IME – Research time is not funded.

- Research rotations need to be very carefully designed; it helps to make sure a project that is presented or published comes from the month.
### GME funding for Fellowships

- **ACGME approved fellowships**
  - Fellows are treated as residents for DME & IME
  - Since they are training longer than their initial residency program, 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

### Counts

- **Accreditation count**: number of approved positions
- **FTE Count**: number on the payroll
- **Resident Count**: FTE minus rotations that the hospital cannot count
- **CMS Cap**: set in 1996

### How do we count residents?

Accreditation count (Program compliment)>
FTE count (Employed)>
Resident Count (Employed – out rotations)>
CMS cap
Counts

TOTAL EMPLOYED (what the administrators pay for) > CAP (the reimbursed amount)

See the issue?

Reporting to CMS

- Intern Resident Information System (IRIS)
  - Must demonstrate hours – new standard is computerized logging system
  - In recent CMS audits, many hospitals that ‘share’ residents between sites have had to account for their residents’ time by the hour.

- To most successfully maximize GME funding
  - Hospital should to keep residents “above the cap” in IRIS system due eliminated times of reimbursement for each resident.

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)
- The work more than the “usual FTE”, some time twice as much (up to 80 hours)
Which way is the wind blowing?

- Changes to the cap require legislation…it’s a political question
- Most HCR proposals have recommended reductions to GME or certainly Medicare funding
- Recent bill proposed increases cap slots by 15,000 and provides for increased payments
- More on this later

Smart money

- Most think it is going to go down, less slots? Less per slot? Doesn’t matter…it’s less money
- In a survey of DIOs…most would cut programs or program size if GME money is reduced
All finance is local

Residents make the hospital money, right?

GME Reimbursement

GME Reimbursement
Residents make the hospital money?

<table>
<thead>
<tr>
<th>Cost per resident FY 2011</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Revenue</td>
</tr>
<tr>
<td>Expenses</td>
</tr>
<tr>
<td>Difference</td>
</tr>
<tr>
<td>Total FTE Count</td>
</tr>
<tr>
<td>Cost per resident</td>
</tr>
</tbody>
</table>

What can we do?

- Raise more revenue for GME
- Raise the number of reimbursed cap positions
- Control costs

More revenue, more slots

- Charge medical schools for clerkship
- Private industry
- Third party foreign support
- Rural hospitals supporting fellowship training in exchange for graduate's time
- Seek redistributed cap slots
- Grow new positions in virgin hospitals...then aggregate
- Acquire other teaching hospitals that have slots and aggregating
- Develop accredited PA programs...claim reimbursement
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”
- Not clear what the “all in policy” will do to these arrangements
Rural community support
• This is happening now too
• A small town needs a cardiologist
  • Incentivize the physician
  • Incentivize the hospital

Seek redistributed slots
• When hospitals closed, their GME slots evaporated
• Now when hospitals close, the slots can be redistributed
  • Complex rubric for priority ranking
  • Application made to CMS
  • CMS determines redistribution

Grow GME in virgin hospitals
• Develop GME training in virgin hospitals, “build a cap”
• Once cap mature, aggregate slots through affiliation
Acquire and aggregate

- Lots of rules here
- Ownership is complicated
- Sure wouldn’t be the reason to buy a hospital

PA GME Programs

- Not physician GME…but GME to augment the workforce
- ARC-PA accredits PA residency programs, similar to ACGME
- Can “claim” on your cost report (a small amount) …but all of the other benefits of resident workforce

Controlling costs?

- Internal cap adjustment to eliminate high cost/low value programs and grow others
- Centralize GME costs to improve efficiency
- Control GME costs by scrutinizing out rotations, teaching dollars, electives
- 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
Right size the programs

- Do some programs need more residents? Do some need less?
- Hospital CEO, "I noticed we have few patient days each year, why do we still have the same number of medicine residents?"

- This is complicated and needs a broader workforce discussion with administration

How many caregivers do you need?

- 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 FTE),...but why have more than we need?
**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

**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?

**Tragedy of the commons**
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
- “Zero based, scripted budgeting”

Resident Salaries

- Stagnate salaries
- Redistribute salaries after reduction
  - Orthopedics paid less
  - Family medicine paid more
- Residents pay tuition
- Eliminate resident perks and benefits

Teaching Dollars
One big bucket

- We pretend like these are discrete financial entities but they are usually part of a larger parent

- How do we make money? When physicians care for patients, perform billable services, or order billable services

- There is increasing pressure on teaching time… Brought about by increasing pressure on RVU productivity

What should programs do?

- Understand the global institutional pressures
- Become a partner with administration, work to be prudent stewards of hospital resources

- Find a way to value your program… and articulate it to other in terms they value

Who values what?

- Program Administration
  - Career progress tied to program value
  - Career work tied to program role
- Program Faculty
  - Enjoy the teaching environment
  - Facilitated patient care
- Parent Department (often weighed differently)
  - Enhanced clinical operations
  - Education success bragging rights
  - Research successes
Who values what?

- GME office
  - Value breadth and depth
  - Responsible program partners
- Finance office
  - Enhanced (or impaired) clinical billing
  - Program analytics (watch their analysis)
- Marketing
  - Program/departmental successes
  - "Sexy" service lines

Who values what?

- Medical school affiliation
  - Clinical teaching
  - Uniform experience for students

Other value impactors

- Non-core service rotations, how many, why?
- Resident impact on faculty productivity
- Faculty supervision type impacts resident value
- Changing healthcare delivery model
- Resident duty hours… 80 versus 40
Why do we care about resident funding?

• Now you can determine how much money your residents are worth to the institution… & how much they are skimming off the top

• Things to do now:
  o Become best friends with the hospital CEO/CFO
  o Determine what you can do to maximize resident funding
  o Develop a proactive budget

Creative Financing of EM Residency

Ways to maximize your current residents & program

• Only match residents who have no prior training
• Move rotations to hospital with higher PRA for DME
• Move rotations to hospital with higher % Medicare patients
• Move rotations to hospital with DSH funding (minimal now)

Creative Financing of EM Residency

• Other government funding opportunities
  o VA hospital funding – no real caps
  o Affiliations with hospitals that have never before had residents
  o Rural hospital affiliation – 50% of training must take place there to increase caps
  o Resident closures – take on additional residents from hospitals that closed and the new hospital has a temporary adjustment up in their caps.
    o Does not work if hospital just eliminates one program
Creative Financing of EM Residency
• Hospital/group reimbursement
  • Payment for use of residents in ED instead of mid-levels
  • EM residents can provide in-house code coverage, MRI infusion staffing
  • EM resident external moonlighting increases rural referral patterns

Creative Financing of EM Residency
• International residents who pay for direct costs of rotation
  • George Washington University model
    • $85,000 administrative fee/resident
• Educational courses taught by residents (ACLS, simulation, procedure courses)
• Research/grant money

Residency Finances
The other side of the story...
Why do we care???

- Develop an indisputable budget
- Understand your residency’s fixed costs
- Know where you can cut funds when asked

Residency Finances

### Annual Residency Budget Comparison

<table>
<thead>
<tr>
<th>Program item</th>
<th>Community</th>
<th>University</th>
<th>Public/City</th>
</tr>
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<tbody>
<tr>
<td>Personnel cost</td>
<td>Salary</td>
<td>47,290</td>
<td>49,931</td>
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<tr>
<td>Benefits</td>
<td>8,500</td>
<td>8,500</td>
<td>8,500</td>
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<td>Malpractice</td>
<td>7,500</td>
<td>7,500</td>
<td>7,500</td>
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<tr>
<td>Chief’s stipend</td>
<td>2,000</td>
<td>3,450</td>
<td>180</td>
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<tr>
<td>Management system</td>
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<tr>
<td>Accreditation cost</td>
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<td>Memberships</td>
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<td>50</td>
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<tr>
<td>ACEP</td>
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<td>SAEM</td>
<td>160</td>
<td>160</td>
<td>160</td>
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<tr>
<td>Required Training</td>
<td>ACLS/BLS</td>
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<td>300</td>
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<tr>
<td>PALS</td>
<td>195</td>
<td>175</td>
<td></td>
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<tr>
<td>ATLS (+airway course)</td>
<td>650</td>
<td>600</td>
<td></td>
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<tr>
<td>Procedure labs</td>
<td>50</td>
<td>185</td>
<td>82</td>
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<tr>
<td>In-training exam</td>
<td>120</td>
<td>120</td>
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<tr>
<td>Special training courses</td>
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<td>Education Book money</td>
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<td>360</td>
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<tr>
<td>Computer fund-EM1</td>
<td>250</td>
<td>200</td>
<td>0</td>
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<tr>
<td>Conference(s)</td>
<td>Conference (average)</td>
<td>1000</td>
<td>1000</td>
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<tr>
<td>Chiefs conference</td>
<td>1,000</td>
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<tr>
<td>National committee</td>
<td>500</td>
<td>1000</td>
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</table>

Residency Finances

### Global costs

<table>
<thead>
<tr>
<th>Item</th>
<th>Community</th>
<th>University</th>
<th>Public/City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruiting</td>
<td>Residency fairs</td>
<td>1,850</td>
<td>0</td>
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<tr>
<td>Interview hotel</td>
<td>7,000</td>
<td>7,000</td>
<td>7,000</td>
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<tr>
<td>Interview food</td>
<td>10,000</td>
<td>23,355</td>
<td>10,900</td>
</tr>
<tr>
<td>Gizmos (pens)</td>
<td>500</td>
<td>600</td>
<td>600</td>
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<tr>
<td>Research Cost for posters</td>
<td>350</td>
<td>1000</td>
<td>6,500</td>
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<tr>
<td>Presenting residents</td>
<td>5,000</td>
<td>6,000</td>
<td>6,000</td>
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<tr>
<td>Seed money</td>
<td>2,000</td>
<td>2,000</td>
<td>2,000</td>
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<tr>
<td>Recognition</td>
<td>Graduation night</td>
<td>4,000</td>
<td>16,265</td>
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<tr>
<td>Plaques/awards/photo</td>
<td>500</td>
<td>1,000</td>
<td>1,000</td>
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<tr>
<td>On-line products</td>
<td>Ultrasound</td>
<td>1,600</td>
<td>2,575</td>
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<tr>
<td>On-line resources</td>
<td>1,400</td>
<td>5,100</td>
<td>200</td>
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<tr>
<td>On-line testing site</td>
<td>2,500</td>
<td>750</td>
<td>750</td>
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<tr>
<td>Education/wellness</td>
<td>Resident wellness</td>
<td>1,500</td>
<td>5,300</td>
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<td>Resident retreat</td>
<td>1,350</td>
<td>5,795</td>
<td>17,000</td>
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<tr>
<td>Faculty retreat</td>
<td>1,000</td>
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<tr>
<td>Journal/Reading Club</td>
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<td>2,000</td>
<td>1,100</td>
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<tr>
<td>Other Educational consults</td>
<td>1,500</td>
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<td>1,750</td>
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<tr>
<td>Orientation extras</td>
<td>1,200</td>
<td>11,085</td>
<td>1,300</td>
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<tr>
<td>Visiting Lectures</td>
<td>3,000</td>
<td>10,000</td>
<td>23,500</td>
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<tr>
<td>Coordinator training</td>
<td>1,500</td>
<td>1,500</td>
<td>1,750</td>
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<tr>
<td>OSCE</td>
<td>500</td>
<td>1,300</td>
<td>2,650</td>
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</table>
What isn’t included

- Faculty
  - Salary & benefits
  - CME
- Coordinator & secretarial support
  - Salary & benefits
- Office overhead
  - Desks, computers, rental space

Summary

- Follow the money!
  - CMS provides Direct GME & IME funds through hospitals
  - State & local community pay provide some funds
- Know how much your residents are worth
  - Show how much you can maximize their worth
- Develop an indisputable budget by labeling each item & delineating each cost
  - Predetermine what can be cut & how much

This is GME...
Colliding issues

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

- 2012 HHS awarded $200 million to 5 hospitals for NP programs
- MEDPAC recommend *performance based incentives for GME
- Macy foundation funded IOM report due in 2014

Legislative hand wringing

- 2010 National Commission of Fiscal Responsibility and Reform (aka as Simpson-Boyles)
  - Direct GME cut to 120% of resident salary
  - Indirect GME placed at risk
- 2011 Obama recommended reductions in both direct GME and pediatric hospital GME
- There have been a lot of bills aimed at increasing GME and a lot of ideas about reducing Medicare

Political advocacy and GME

- HR 6352 in 112th Congress
- Introduced by Aaron Schock from (R-IL) and Allyson Schwartz (D-PA)
- "Come to Washington, the legislators LD and LA want to check in with 'stakeholders' before the bill is introduced in the 113th Congress"
- Met in a House Office Building room for 1 hour
“Stakeholders” in attendance
- Family Physicians
- Neurosurgeons
- Obstetricians and Gynecologists
- American Osteopathic Association
- American Association of Medical Schools
- American Association of Colleges of Osteopathic Medicine
- Large for profit hospital network from the Midwest
- One of our Government Affairs staff (lobbyist)
- Me

Stakeholders
- Number of lawyers or lobbyists?

Stakeholders
- Number of lawyers or lobbyists?
  - 12
Stakeholders

- Number of lawyers or lobbyists?
  - 12

- Number of doctors in the room?
  - 1

- Number of people who taught medical students, recruited and matched residents, trained residents, made a residency budget, or added any provider to the workforce?
HR 6352

- Fills the "over cap" gap (1/3 of funding)
- Allows for new cap slots (2/3 of funding)
- Allows for 3000 slots per year for 5 years
- Places Indirect GME at risk
- Likely introduced in mid-March

Summary

- Get in the game, it’s a brave new world
- Understand the business of education
- Engage in principled prioritization and negotiation
- Articulate your teaching effort, value it
- Express your value… in their terms