Creative financing:

- Maximize use of current residency spots
  - 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)
- CMS Government funding opportunities
  - VA hospital funding – no caps
  - Develop affiliations with hospitals that have never before had residents
  - Rural hospital affiliation – 50% of training must take place there to increase caps
  - Possible increase in cap numbers for a state through CMS (Louisiana?)
  - Resident closures – take on additional residents from hospitals that closed and the new hospital has a temporary adjustment up in their caps.
- Hospital/group private reimbursement
  - Payment for use of residents in ED instead of mid-levels
  - Negotiate faculty time instead of resident salary or other direct monies
  - EM residents can provide in-house Code coverage,
  - EM resident external moonlighting increases rural referral patterns
- Military Residents – US Military pays for salary & benefits
- International residents who pay for direct costs of rotation
  - George Washington University - $85,000 administrative fee/resident http://www.gwumc.edu/imp/education/internatres.cfm

Increase Revenue:

- Charge medical schools for your teaching rotations
  - If you are affiliated but not owned by a school
  - For International Medical Schools (St. George's, Ross)
    - 3rd year –
    - 4th year rotation -
- Private Industry
  - Device manufacturers
  - Pharmaceutical companies
  - Contract Management Groups (pay for lectures, resident educational expenses)
- Educational courses taught by residents (ACLS, simulation, procedure courses)
- Residents help with coding EM charts
- Research/grant money

Acronyms & Definitions:

Cap – Total number of residents/fellows CMS will pay for in your system from 1996
CBSA – Core Based Statistical Areas – socio-economically tied regions around a city often used by federal government to identify medical service areas
CMS – Center for Medicare & Medicaid Services – federal agency that pays for GME funding
DME or DGME – Direct Graduate Medical Education – reimbursement to hospitals for costs such as resident salary, benefits, and faculty and hospital overhead expenses
DSH – Disproportionate Share Hospital funding – additional funds for hospitals with more than 30% of patients whose payments come from indigent care funds
IME – Indirect Medical Education adjustment – higher operating cost to the hospitals from teaching activities including increased lengths of stay & higher acuity patients.
IRB – Intern & resident per bed ratio at each hospital used to calculate IME
IRP – Initial Residency Period – first GME program a resident enrolls in which sets the number of years for their full-time payment from CMS
IRIS – Intern Resident Information – reporting system of resident to CMS also known as the "Cost report"
PRA – Per Resident Amount – used to calculate DME

References:

Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Graduate Medical Education That Meets the Nation's Health Needs. Washington (DC): National Academies Press (US); 2014. https://www.ncbi.nlm.nih.gov/books/NBK248022/

Henderson TM, "Medicaid Graduate Medical Education Payments: A 50-State Survey." Association of American Medical Colleges, 2013.

Wynn BO, Smalley R, Cordasco KM. "Does it Cost More to Train Residents or to Replace them? A look at the Costs and Benefits of Operating Graduate Medical Education Programs." Rand Corporation Research Report, 2013.

Wynn B, Guarino C, Morse L, Cho M. "Alternative Ways of Financing Graduate Medical Education" Rand Health, 2008.