Managing the Graduate Medical Education
Bottom Line

April 13, 2011
Today’s Agenda

• Brief introduction

• What is in the future for GME funding?

• How to assess and manage the GME bottom line
  – Yes, there is one

• What is the strategic value of GME?

• Questions and answers
The Future of Graduate Medical Education Funding
Over the past several years there have been several regulatory and policy changes impacting GME.

<table>
<thead>
<tr>
<th>1990’s</th>
<th>2000’s</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident caps</td>
<td>Some relief measures</td>
<td>Relaxed rules around community rotations</td>
</tr>
<tr>
<td>Ability to fully claim</td>
<td>More complicated rules around community rotations</td>
<td>2nd round of reallocated positions, with full</td>
</tr>
<tr>
<td>community rotations</td>
<td>and scholarly activity</td>
<td>funding but geographic and program limitations</td>
</tr>
<tr>
<td>Start of reductions in IME funding</td>
<td>Reallocation of unused residency slots, though at reduced funding</td>
<td>Less administrative burden</td>
</tr>
</tbody>
</table>

Over this period of time we have operated under the premise that there was an oversupply of physicians, with rules and funding changes to stem the growth of trainees. Currently there is acknowledgement of a growing physician shortage, but the rules and funding do not appear to be set to accommodate growth.
While it may be easier today to claim residents, the future challenge may be how you can fund and sustain the GME enterprise.

**MedPAC**
- Reduce IME by some amount (up to half) based on empirical evidence that teaching hospitals are overpaid.
- Savings can be used to support initiatives such as pay-for-performance and accountability in GME.

**IPAB**
- Implementation of spending cuts if Medicare spending exceeds certain target growth rates.
- Proposals will be implemented unless Congress passes alternative ways to achieve savings.
- First time Medicare subject to spending limits.
- Hospitals excluded until 2019.

**Budget Cuts**
- National Commission on Fiscal Responsibility and Reform’s “Moment of Truth” report recommended IME be cut over half current IME rates. (December, 2010).
- Limit PRA to 120% of national average.
Health Reform and other policy recommendations have also touched upon areas that could further impact the GME bottom line.

**DSH**
- Significant reductions (both Medicare and Medicaid) based on complex formula, beginning no later than 2015 for Medicare.
- Teaching intensity often correlated to higher DSH payments.

**Primary Care/Transparency**
- New record keeping requirements to track and create base year (7/1/09-6/30/10) for primary care FTEs on cost report.
- Tying of costs to reimbursements by program?

**THC**
- Opportunity through HRSA to receive full IME and DME funding for sponsorship of residency training in the community.
- Enhancement of primary care training through health centers.
While the Teaching Health Center grant opportunity sounds appealing, it will only help a select group.

<table>
<thead>
<tr>
<th>Funding</th>
<th>Timing</th>
<th>Programs</th>
<th>THC Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>IME and DME payments. Not tied to Medicare utilization. Up to $150,000 per resident. $230m over five years. Compared to $10b annually from Medicare.</td>
<td>First round of funding occurred last month. $1.9m awarded to 11 new THCs for three months. Future awards to cover full years and more FTEs. 2011 through 2015.</td>
<td>Primary care programs, including: family medicine, internal medicine, peds, med-peds, ob-gyn, psych, general and pediatric dentistry, and geriatrics.</td>
<td>Community-based, ambulatory patient care center operating primary care program(s). FQHC CHC Rural/Tribal/Indian Health/Title X clinics</td>
</tr>
</tbody>
</table>

- A significant barrier to the establishment of a THC is the requirement of the entity to hold program accreditation. However, a consortium model can be used.
- The biggest rub is CMS’s position that participating hospitals cannot exceed its caps if participating in a THC program, contrary to HRSA’s initial position.
Key considerations about where GME financing may be headed:

- IME has for the past several years been under the microscope.
  - Many of the technical GME changes, policy decisions, and external recommendations have been chipping away at this payment

- The focus on primary care training has never been greater.
  - New cost reporting requirements
  - THC initiative
  - MedPAC recommendations
  - Potential tie of reimbursement to costs per resident and primary care requirements.
  - Pay-for-performance with primary care thresholds

- As we look to the future, understanding the strategic and economic value of GME and the associated costs is crucial to effectively manage the GME enterprise.
How to Assess the GME Bottom Line
The framework we use to assess program feasibility is also a way to better understand the current and future investment in GME.

**Economic**
- What are the sources of reimbursement?
- How do we optimize future reimbursement?
- How much does it cost to support GME?
  - Direct costs
  - Indirect costs
  - Opportunity costs

**Programmatic**
- Infrastructure needs such as faculty and space requirements.
- Recruiting costs.
- Accreditation path and associated costs:
  - Osteopathic
  - Allopathic
  - Dual-accreditation

**Operational**
- Where are the residents deployed?
  - Affiliations with other hospitals
- How are continuity of care and elective rotations addressed?
- Who oversees and trains the residents?

**Strategic**
- How are programs aligned with the current and future needs of the community?
- How do we compete with other programs?
- What are the related benefits of having GME programs?

As the economic assessment is made, it is likely some programs are more costly than others, and require subsidization.
The challenge: figure out how to credit GME for the benefits it provides, and what it costs to support residency training.

**Economic**

- What are the sources of reimbursement?
- How do we optimize future reimbursement?
- How much will it cost to support GME?
  - Resident costs
  - Physician costs
  - Infrastructure costs

- Medicare IME and DME is the focus, but what about other sources of reimbursement and related benefits?
  - Clinical revenues
  - Commercial payers
  - DSH
  - Medicaid
  - Philanthropy
  - Downstream benefits such as saving on recruiting costs and retention

- While there are direct and indirect benefits to GME, there are also direct and indirect costs that cannot be overlooked.

Often times reimbursement is kept to just IME and DME, with an understanding that there are other benefits that GME provides. On the cost side it is important to understand the shortcomings of DME (and hence the importance of the IME subsidy).
For many hospitals the DME it receives is based on an inaccurate average per resident amount.

Average Per Resident Amount: $74,604
In this example, the average cost per resident is nearly twice the actual PRA.

Actual Per Resident Cost: $144,017

- Resident: $72,747
- Faculty: $44,418
- Administrative: $13,705
- Other than Salary: $3,185
- Indirect Stepdown: $9,963
The net amount of DME reimbursement received further emphasizes the importance of IME.

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual cost per resident</td>
<td>$144,017</td>
</tr>
<tr>
<td>APRA</td>
<td>$74,604</td>
</tr>
<tr>
<td>Medicare utilization</td>
<td>41.93%</td>
</tr>
<tr>
<td>Approximate DME per resident</td>
<td>$31,281</td>
</tr>
<tr>
<td>Difference between Cost and DME</td>
<td>$112,736</td>
</tr>
</tbody>
</table>
We look at the current complement of programs and the hospital’s ability to sustain training, along with current and future hospital needs, and market forces.

<table>
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<th>Programmatic</th>
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<tr>
<td>Infrastructure needs such as faculty and space requirements.</td>
</tr>
<tr>
<td>Recruiting costs.</td>
</tr>
<tr>
<td>Accreditation path and associated costs:</td>
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<tr>
<td>- Osteopathic</td>
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<tr>
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</tr>
<tr>
<td>- Dual-accreditation</td>
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</tbody>
</table>

- Once the PRA is set, the most misunderstood and loosely tracked cost is faculty.
  - The split between non-billable teaching and clinical revenue generation can be blurred over time because this doesn’t influence DME anymore.
- For mature programs, cap slots can become sacred, rather than adapting to market forces or community needs and reallocating positions from within.
- Dual-accreditation can increase the recruiting pool, but can the additional costs be sustained?

As we’ve discussed, the tide is shifting towards rewarding or eventually incentivizing hospitals to further emphasize primary care, yet those programs can be the most difficult to fill.
Where residents are deployed can influence both program economics and ability of a hospital to meet program requirements.

Operational

- Where will residents be deployed?
  - Affiliations with other hospitals
- How will we accommodate clinic rotations?
- Who will oversee and train the residents?

- Some rotations need to be performed at hospitals not part of your own health system.
  - Cost of doing business or program attractiveness?
- Off-site, continuity of care rotations may result in increased faculty costs or the need to establish new clinic space.
  - Will community physicians go back to “volunteering” their time, or will a payment be required?
  - What are the clinic economics?

Though some rotations may need to be performed at other hospitals, with established training a hospital can claim residents who rotate in from other approved GME programs, potentially offsetting that cost.
To put some of this in perspective, here is an example of a typical economic assessment of GME.

<table>
<thead>
<tr>
<th>Number of Claimed Residents</th>
<th>44.25</th>
<th>51.17</th>
<th>52.83</th>
<th>54.33</th>
<th>56.00</th>
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</tr>
</thead>
<tbody>
<tr>
<td>PROGRAM REIMBURSEMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IME</td>
<td>FY11</td>
<td>FY12</td>
<td>FY13</td>
<td>FY14</td>
<td>FY15</td>
<td>FY16</td>
<td>FY17</td>
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<tr>
<td></td>
<td>$3,973,655</td>
<td>$4,224,925</td>
<td>$5,067,186</td>
<td>$5,557,786</td>
<td>$5,890,986</td>
<td>$6,179,800</td>
<td>$6,425,874</td>
</tr>
<tr>
<td>DME</td>
<td>1,560,637</td>
<td>2,226,886</td>
<td>2,688,032</td>
<td>2,956,911</td>
<td>3,761,096</td>
<td>4,668,810</td>
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<tr>
<td>Other funding</td>
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<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Reimbursement</td>
<td>$5,534,292</td>
<td>$6,451,811</td>
<td>$7,755,218</td>
<td>$8,514,697</td>
<td>$9,652,082</td>
<td>$10,848,610</td>
<td>$12,124,124</td>
</tr>
<tr>
<td>PROGRAM EXPENSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>$5,625,392</td>
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<td>Other Than Salary</td>
<td>606,427</td>
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<td>763,293</td>
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<tr>
<td>Total Direct Expenses</td>
<td>$6,231,818</td>
<td>$7,032,470</td>
<td>$7,390,596</td>
<td>$7,720,449</td>
<td>$7,925,188</td>
<td>$8,162,944</td>
<td>$8,407,832</td>
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<tr>
<td>Contribution Margin</td>
<td>$(697,527)</td>
<td>$(580,659)</td>
<td>$364,622</td>
<td>$794,249</td>
<td>$1,726,894</td>
<td>$2,685,666</td>
<td>$3,716,292</td>
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It is not uncommon for hospitals to stop the analysis here—basing its GME profitability on IME and DME reimbursement, but not recognizing indirect costs.
Often overlooked, or ignored, is the impact of indirect costs because they are difficult to quantify.

When taking into account indirect allocated costs, the overall margin suffers and the investment in GME increases. This is also assuming that the total IME reimbursement exceeds estimated IME costs.
If the recommendations of MedPAC and the bipartisan national commission to cut IME come to fruition, the economics of GME will be severely constrained and the vast majority of teaching hospitals will require a subsidy.

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### Program Reimbursement

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<tr>
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### Program Expenses

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### Contribution Margin

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<td>$ (1,807,697)</td>
<td>$ (1,022,214)</td>
<td>$ (139,233)</td>
<td></td>
</tr>
</tbody>
</table>

### Indirect Allocated Costs

<table>
<thead>
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<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
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<tbody>
<tr>
<td>$1,333,034</td>
<td>$1,455,992</td>
<td>$1,731,648</td>
<td>$1,885,490</td>
<td>$931,356</td>
<td>$972,747</td>
<td>$1,009,211</td>
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</table>

### Total Expenses

<table>
<thead>
<tr>
<th>Year</th>
<th>FY11</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>$7,564,852</td>
<td>$8,488,462</td>
<td>$9,122,244</td>
<td>$9,605,939</td>
<td>$8,856,544</td>
<td>$9,135,690</td>
<td>$9,417,043</td>
<td></td>
</tr>
</tbody>
</table>

### Profit/(loss) from GME Activities

<table>
<thead>
<tr>
<th>Year</th>
<th>FY11</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14</th>
<th>FY15</th>
<th>FY16</th>
<th>FY17</th>
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<tbody>
<tr>
<td>$(2,030,560)</td>
<td>$(2,036,651)</td>
<td>$(1,367,026)</td>
<td>$(1,091,241)</td>
<td>$(2,739,053)</td>
<td>$(1,994,961)</td>
<td>$(1,148,444)</td>
<td></td>
</tr>
</tbody>
</table>
Key considerations about how to manage the GME bottom line:

- Our example includes just IME and DME, but also considers an offsetting indirect cost.
  - Why would Medicare provide IME reimbursement if there were no IME cost?
- Other sources of reimbursement can and should be considered, because GME has both a direct and indirect impact to the overall finances of a hospital.
- By including other sources of reimbursement, the analysis can become more complex and difficult to address because for every dollar received, there is almost certainly a cost associated with receiving that benefit.
- Ultimately, the investment in GME needs to be tied to both quantitative and qualitative measures.
  - You cannot dabble in GME
What is the Strategic Value of GME?
Today’s environment suggests a more comprehensive understanding of GME is necessary, beyond the bottom line.

Teaching hospitals will need to define with GME means to their organization, beyond the ability to fill slots or capture IME and DME. The strength of the commitment to GME will influence how successful the hospital will be as the economics of GME may change in the future.

Strategic

- How are programs aligned with the current and future needs of the community?
- How do we compete with other programs?
- What are the related benefits of having GME programs?

Focus on education vs. services, and enhanced quality.
- Physician succession planning and recruitment, and ability to retain physicians.
- Enhanced faculty skills.
- Strengthen or creation of academic affiliations, and an environment of scholarly activity that can lead to research funding.
- Call and coverage.
Questions and Answers

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617 963-8240  
cfrancazio@pkfhealth.com