GME Funding: Beyond the Basics and Creative Options

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Webinar Sponsor

- Presented Under the AHW Graduate Medical Education Development in Central and Northern Wisconsin Grant: Grant Awardee, The Medical College of Wisconsin
- WI Collaborative for Rural Graduate Medical Education (WCRGME) – Program of the Rural Wisconsin Health Cooperative: Grant Project Manager

The Purpose of this Webinar

- Review the basics of the Centers for Medicare and Medicaid (CMS) reimbursements for graduate medical education (GME)
- Address special rural program considerations
- Point out pitfalls in CMS reimbursements
- Share options for advocating change in Medicare rules
- Case study: Advocating for stakeholder investment – Monroe Clinic
The basic costs...

- Costs of “mature” residency range from $120,000-$150,000 per FTE resident per year
- Start-up costs add ~$1,000,000 million over 5 years (maybe $500,000 if RTT with urban program infrastructure support)
- This does NOT include costs to build/remodel space (e.g. new clinic) or costs to build a practice for newly hired faculty.
- Actually running a primary care practice often requires health system “subsidy” whether a teaching or nonteaching practice.

The “usual” revenue...

- Startup costs require grants (if available) plus stakeholder investment.
- Ongoing costs usually covered by Medicare GME $ if available and sufficient given your hospital(s)’ situation.
- Any shortfall in Medicare GME $ requires creative financing:
  - Medicaid GME
  - State grants
  - Ongoing stakeholder investment. Recognition of value added by GME.

Medicare GME composed of DGME and IME

- DGME is based on:
  - a “Per resident amount” (PRA) set when hospital first has residents
  - Roughly $90,000 for new WI teaching hospitals
  - PRA times Medicare’s share of bed days times FTE residents claimed (allowed claims)
- IME is based on:
  - “Intern resident bed ratio” (IRB)
  - DRG $ volume
  - Formula calculates an add-on for each DRG $
**WI teaching hospitals FY 2013**

Total Medicare GME $ for WI teaching hospitals $158,078,656

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<th>Hospital Name</th>
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**Pitfalls in getting Medicare GME $ for new residencies**

- Not being a “regular” IPPS hospital:
  - Sole Community Hospitals get less IME if paid at community rate (only IME for Medicare Advantage)
  - Critical Access Hospitals get neither DGME nor IME but can get “Medicare’s share” + 1% of residency costs – similar to DME math
Pitfalls in getting Medicare GME $ for new residencies

- Not being a “virgin” IPPS hospital:
  - You already have a PRA and/or a cap based on prior cost report claims
  - Base year when residents rotate sets PRA
  - 3 (now 5) years to set cap once residents from 1st NEW program rotate
  - You had residents “doing regular planned rotations” in hospital but didn’t claim them…but should have and then CMS (Medicare) sets PRA at zero (no DGME forever) and might have very small cap.

Pitfalls in getting Medicare GME $ for new residencies

- Your new residency is not judged to be “new”.
- Criteria for newness (need all 3):
  - New (separate) program director
  - New (separate) faculty
  - New (separately recruited) residents

Pitfalls in getting Medicare GME $ for new residencies

- You don’t have much Medicare volume
- Particularly an issue with rural hospitals that do a fair amount of maternity care (no Medicare) and not much surgery (hips and knees for old folks).
Pitfalls in getting Medicare GME $ for new residencies

• Your urban hospital already has an RTT and thus a “urban hospital RTT cap”
  • RTT “cap adjustment” for urban hospitals is set 3 (now 5) years after first claim for first RTT residents claimed.
  • Specialty specific - meaning could do a second RTT in another specialty if that was even possible.
• Medicare definition of an RTT:
  • >50% of residents' training is in a “rural” area(s)
  • “rural” means not in a metropolitan CBSA

Medicare GME "rural" is light green or white:
google “cbsa census maps”

Pitfalls in getting Medicare GME $ for new residencies

• You thought you were “rural” but you are not
  • “rural” hospitals can reset their cap clock (build a higher cap) whenever they start a new residency – especially in a different specialty.
• CBSA designations change with each 10 year census. Next in 2020… but there can be mid-census adjustments.
So if little to no Medicare GME $ what to do?

- Advocate for change in Medicare GME rules (new laws);
- Advocate for state funding (often via Medicaid match)
- Advocate for stakeholder investment

Advocate for change in Medicare GME rules (new laws)

- Ribble-Nelson bill
  - Entire WI congressional delegation co-sponsoring currently... except 1st district (Ryan)

- IOM report framework for global change
- Other bills coming down the pipeline.

Apply for (and advocate for more) state funding - often enhanced via Medicaid match

- WI grant programs for residency expansion and new residencies
Case Study: Advocating for stakeholder investment
Monroe Clinic

Funding GME at Monroe Clinic

Our Path to GME Sustainability
- Wisconsin Rural Physician Residency Assistance Program
- Strategy of investment for Physician Pipeline to our Health System
- WI Department of Health and Human Services Grant RFA #G-0293-OPIB-14. New Residency Training Program
- Establishing new GME CAP
Grant Funding to Support Development

Remodeling and Expansion

Adjusting Course as Needed

- County re-designated from rural to urban at time of accreditation submission
- CMS “new program” definition
- Identified need for legal consultation and GME consultant to assist with planning
- Opportunity for transfer “orphan” residents from nearby AOA program
Sustainable Growth Strategy

- What is the end product of our Value Stream?
  - Culture
  - People/Staff
  - Physical Space
  - Regulatory
  - Educational Partnerships/Sponsorship
  - Money
    - Graduate Medical Education
    - Further Grant Funding
    - Reduce Expenses

Advocate for stakeholder investment

- Medical Staff
  - Succession Planning
  - Keeping it Fresh
- Board
  - Recruitment Strategy
  - Culture of Learning
- Management
  - Recruitment Strategy
  - Work-flow redesign
  - Community Care Narrow Network
- Community
  - New Partnerships with Medical Community
  - Pipeline of learners within our Community
  - Diversity of Providers for our Community.

People + Passion = Possibility