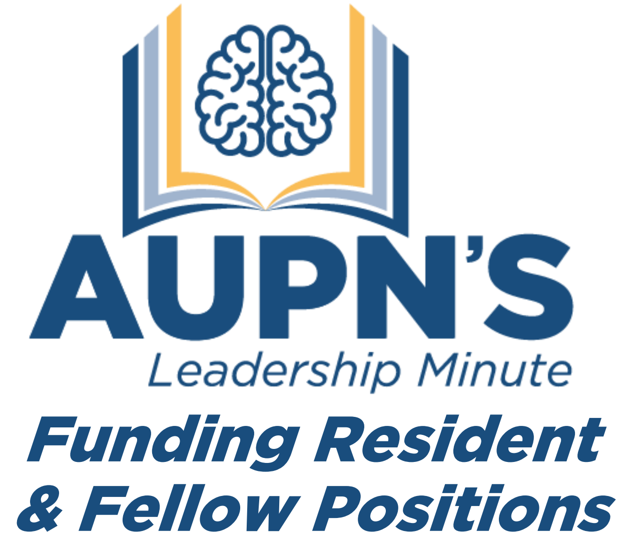

Funding Resident & Fellow Positions

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Leadership Minute Podcast Episode Description

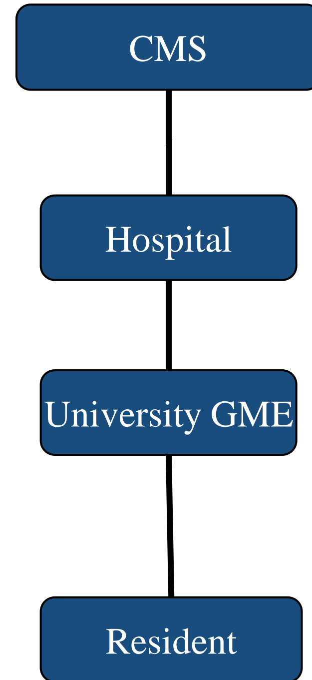
- This leadership minute will provide an overview of how the U.S. Graduate Medical Education funding model works, including discussion of possible mechanisms to increase funding lines in your program.

AUPN
Association of University Professors of Neurology

Medicare GME Payment Policy

- Section 1886 of the Social Security Act stipulates that Medicare-participating hospitals can receive separate payments for approved graduate medical education activities
- Payments above and beyond the standard DRG patient care payment
  - Hospitals are reimbursed for both direct GME (DGME) costs and "indirect" medical education (IME) costs
  - Hospitals are reimbursed based on count of residents training in hospitals and non-provider settings (e.g., physician offices)

Simplified GME Funding Model:



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DGME/IME Summary

Direct GME - ~1/3 total dollars

- Covers direct cost of the residents and fellows: Salaries and Fringe Benefits

Indirect GME - ~2/3 total dollars

- Intended to cover additional cost of treating patients by residents (compensate for increased patient complexity seen at academic centers and increased operating costs (lower productivity) associated with being a teaching hospital)

The Medicare Resident Cap

- The Balanced Budget Act established a cap on the number of residents each hospital can count for Medicare payment purposes
  - Teaching hospitals not paid for training more residents than they were training in 1996
- A hospital's caps (one for DME and one for IME) are "attached" to a hospital's provider agreement with the Medicare program
- Many hospitals have increased training above their caps nonetheless (hospital funds GME on its own).

How to expand your residency program?

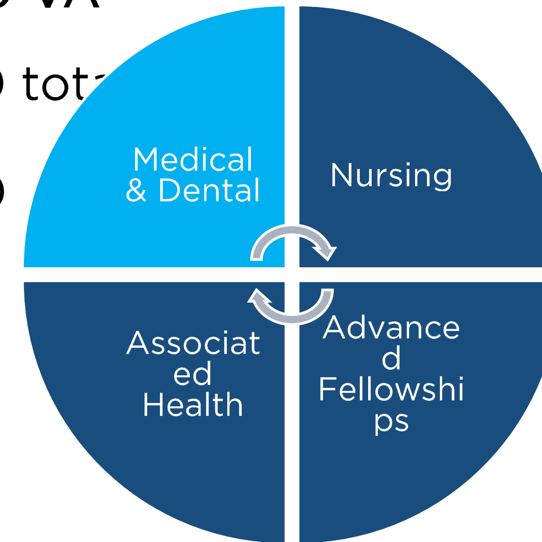
- Obtain additional slice of hospital's fixed CMS supported GME FTE pie
  - If hospital is under CMS FTE cap this is a straightforward process (but usually only applies to rural hospital systems).
  - At large academic centers this usually involves reassigning FTE from another program that is underutilizing its FTE at a given hospital.

- Obtain Hospital Funding for FTE over CMS cap
  - This usually involves convincing hospital leadership of value added in terms of revenue and patient services (asking hospital to "foot the bill").

- Find finding source other than CMS (VA, Industry, Department, Philanthropy)

VA GME Funding

GME FTEE 11,500 VA
70,000 tot
Dental 350
UME` 27,000



Medical Students

Medical Residents

Dental Students and Residents

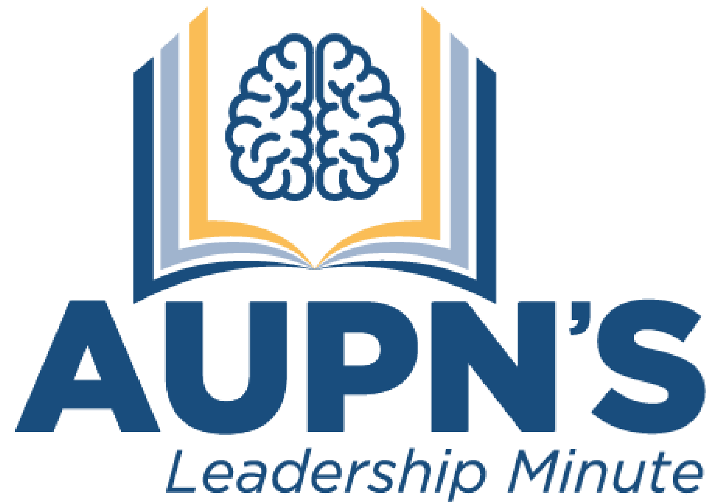
Threats/Tips in the Process

- Competition for limited slices of the CMS FTE pie
  - particularly from departments seen as better revenue drivers for the hospital-(”cognitive” vs. procedural specialties).
  - Emphasize support functions high value hospital services and downstream revenue (critical care, stroke, epilepsy surgery, spine surgery, radiology, infusion services).

- Time and labor-intensive process.
  - Arm yourself with data to support your case.
    - Show increased volumes, peer institution FTE’s
    - Improved ER throughput, hospital LOS, etc.
    - Cost of alternative: APP’s, tele-neurology, etc.

Engage Allies in the Process:

- Designated Institutional Official (DIO)
- Dean of the Medical School
- Affiliate Hospital Leadership (CEO, QI/QA Advocates)
- VA Leadership (CMO and ACOS for Education)



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