The RTT Collaborative
in rural health professions education and training
Growing our own...together

GME Revenue and Expenses and the Value of Residency Training

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Today's Agenda

- Introductions
- GME feasibility framework
- GME economics
- The value of residency training
- Illustrative pro forma
- Q&A

GME Feasibility Framework

Though program design is critical to GME success, one of the initial considerations is how much will it cost and can it be sustainable.

Economic	Programmatic	Operational	Strategic
▪ What are the sources of reimbursement? ▪ How do we optimize future reimbursement? ▪ How much will it cost to support GME? ➢ *Direct costs* ➢ *Indirect costs* ➢ *Opportunity costs*	▪ Who will serve as institutional sponsor? ▪ What programs should we consider to pursue? ▪ What can be sustained, what is feasible in a rural setting?	▪ Where will residents be deployed? ▪ How will we accommodate clinic rotations? ▪ Who will oversee and train the residents?	▪ What is the rationale for having GME programs? ▪ What are the related benefits of having GME programs? ▪ Tied to our mission?
What is the potential ROI with GME?	**What are the greatest needs in a rural environment?**	**Where residents are deployed will influence funding and cap establishment.**	**Workforce/retention, loyalty, downstream revenue, academic partnership(s).**

Each of these focal areas are interrelated and influence the GME bottom line.

There are three distinct phases of GME growth and programmatic development affecting economics.

Significant investment, no offsetting Medicare GME reimbursement.

5 year cap build-up, with establishment of per resident amounts.

Goal to optimize caps and reimbursement, manage costs, and mitigate risks.

Besides HRSA planning grant support, some states and philanthropic organizations may assist with start-up funding. Start up costs are not explicitly reimbursed by Medicare.

Reimbursement and Revenues

The majority of GME funding comes from Medicare, but there are other sources used to subsidize residency training.

Direct Medical Education (DGME)

Direct costs of training, based on PRA

+

Indirect Medical Education (IME)

Add-on payment to offset inefficiencies

Total federal GME payments are approximately $12+ billion.

+

Additional Support for GME

- ***Medical Schools***
- ***Faculty PPs***
- ***Medicaid FFS***
- ***Children's GME***
- ***VA/DOD***
- ***THCs/FQHCs***
- ***Philanthropy***
- ***Others?***

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Total Reimbursement for GME

Hospitals are limited, or capped, at the number of funded DGME and IME FTEs.

The type of site that trains a resident dictates whether Medicare DGME or IME is claimable.

	Type of Traning Site				
	Urban/rural Hospital	SCH	CAH	Nursing Home	FQHC
DGME	Y	Y	N	N	Y/N
IME	Y	Y*	N	N	N

* A sole community hospital paid at a higher, hospital-specific rate qualifies for partial IME; full IME is claimable if SCH is paid at the federal rate.

In addition to the location of training, approved resident activity performed at each site (e.g., patient care, non-patient care, research) will also determine whether DGME or IME is claimable.

Participation in a rural GME program can provide enhanced allowable reimbursement to an urban hospital, even if capped.

- **Rural Training Track Programs ("RTT")**
  - RTT programs provide an opportunity for urban and rural hospitals to partner and promote rural training.
  - New RTT programs can present an opportunity for urban hospitals to obtain cap relief, separate from their base year (e.g., 1996) caps.
  - If residents in an RTT program train in a rural hospital and/or at rural non-hospital sites for more than one-half of their training, then the urban hospital can receive an RTT cap.
    - Time spent by residents in the urban setting or at rural non-hospital sites can contribute to the establishment of the RTT cap.
    - The cap is established based on a five-year window.
  - Many RTT programs are established as "1-2", with the first year at the urban site and the next two years at the rural site.

Besides Medicare funding, patient care reimbursements should also be considered when estimating the impacts residency training.

- **Direct patient care:**
  - FMC
  - Specialty clinics
  - Inpatient, nursing home, other
  - *Dependent on resident and faculty activity and reimbursement model – increases when all third year positions and faculty positions filled*

- **Other patient service reimbursements**
  - Medical directorships
  - Other service contracts
  - Administrative roles

Factors affecting patient care revenue

- Payor mix of patients
- Billing and collections efficiencies (deductions, write-offs, AR, etc.)
- Volume of patients seen (productivity)
- Service contracts (managed care; enhanced reimbursements)
- RVU production

Other Federal Sources of Revenue

- **HRSA / FQHC**
  - Teaching Health Center grants
  - Primary Care Training Expansion grants
  - Rural Residency Program Development grants
  - Children's hospital GME
  - Other grants that may indirectly help
- **Veterans Administration**
  - VACAA: "Choice Act"
  - "Mission Act"

Other Revenue Sources

- **State funding**
- Other sources:
  - Community Support
    - Foundation
    - Individual
  - Grants
  - Research
  - Other
- **Institutional direct support**

Revenue Threats and Opportunities

- **Threats:**
  - GME funding sources, both federal and state
  - State revenue streams
  - Practice pressures (EMR, PCMH, etc.)
  - Threats to the THC and other federal health programs

- **Opportunities**:
  - The future of federal and state health programs
  - Practice transformation
  - CMS initiatives (ACO; quality payment systems, etc.)

GME Expenses

GME expenses vary by market and by program, but keep in mind: it is a fallacy to think that good programs can be run cheaply.

Faculty Time

- Standards vary by program for:
  - Program director
  - Core faculty
  - Other faculty, such as community-based

Resident Costs

- Driven by Fair Market Value and historical rates- not Medicare.
- Will be a standardized amount.

Other Costs

- Dedicated coordinator.
- Clinic costs.
- Research costs.
- Didactics and other educational modules.
- Capital costs.
- Indirect costs.

Medicare requires hospitals to substantiate its costs in order to obtain allowable reimbursement. ACGME standards do not coincide with CMS requirements, which can result in additional costs that may not be reimbursable.

Faculty Time considerations

- Program director:
  - FTE to program admin? Billable resident supervision? Direct patient care?
- Program faculty:
  - Similar questions
  - How many faculty and total FTE?
- Other faculty:
  - Who else is needed for this program?
    - Specialty physicians
    - Non-physicians
  - Who else might be available electively?
  - How many of these may require payment for teaching services provided?

Faculty Cost considerations

- Other faculty expenses:
  - Faculty recruitment
  - Faculty development, including conference time/travel and engagement in teaching society memberships

Resident Cost considerations

- Resident salaries
- Resident benefits

Other Cost considerations

- Program administrative support:
  - Program coordinator
  - Additional support staff related to size of program

Other Costs: Incremental Clinic Staffing to support residency continuity practices

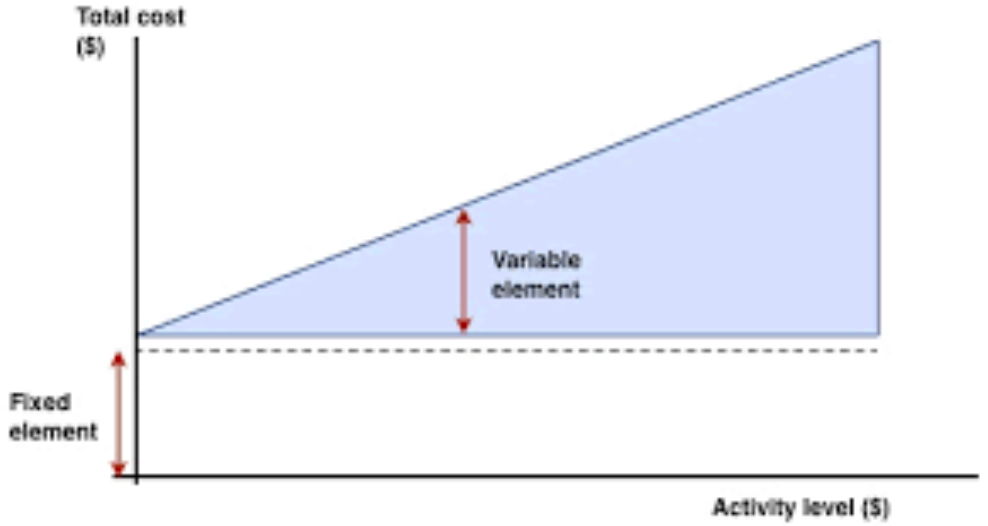
- RN/nursing support
- Medical assistant support
- Physician Assistant or Nurse Practitioner
- Ancillary Staff (MSW, behavioral science counselors, Nutritionist, etc.)

Variable operational expenses

- IT expenses: hardware and software
  - Clinical
  - Non-clinical (RTM system, others)
- Malpractice insurance
- Resident training expenses
  - Accreditation fees
  - Licenses; Board exam fees
  - Courses, dues, CME
  - Food
  - Recruitment

Fixed expenses, including capital and applicable lease payments

- Building/space, both clinic and administration
- Maintenance
- Equipment cost and depreciation
- Other



“Indirect” expenses

- “Indirect” expenses or “overhead”: other costs not directly on the budget sheets but contributing to the support of the program
  - Human resources
  - IT
  - Administration
  - Billing functions
  - Utilities
- ***Highly variable among programs***

What is the value of GME?

Program Impact- what is the rationale for investing in GME?

- Physician workforce contributions
- Service to the community
- Service to the hospital/system
- Improving quality of care

How do we quantify and value GME? What are some of the residual benefits we may receive through our investment?

Recruiting and Referrals

- Big driver here for medical schools and those seeking to make vs. buy.
- Workforce projections demand some action.
- Some hospitals estimate upwards of $100,000+ in recruiting cost savings for each retained resident.

Continuity of Care

- Continuity of care rotations can be a wild card as it relates to GME economics- loss or gain?
- Use of other models, in particular FQHCs, can meet needs of community in a collaborative fashion.

Replacement Costs

- What if we tried to replace a resident or residents?
- Must look at productivity- residents, those who replace them and increased faculty capacity.
- Loss of IME and DGME, and workforce pipeline.

Patient Care

- Call and coverage, PA and locum cost avoidance, other areas in which residents take an active role that can save costs.

Program Impact: Workforce

- New providers / graduates
  - Committed to the community and institution
  - Familiar with local environment
- Reduced recruiting costs
- Catchment referral pattern
- Regional reputation

Program Impact: service to community

- **Direct patient care services provided**
  - Inpatient Care
  - Outpatient Care
- **Meeting community needs:**
  - Community safety net
  - OB/pediatric care
  - Senior care
  - Other specialty care
  - Community outreach projects
- **“Economic Benefit”**

Program Impact: Service to hospital

- Direct revenues:
  - Clinical income generation
  - External reimbursements (CMS, Medicaid, state)
- Direct downstream referrals
- Replacement provider costs

- Faculty leadership
- Controlling costs:
  - Unreimbursed care
  - Avoiding ER over-utilization, readmissions
- **“Community Benefit”**

Program Impact: Quality of care

- Learning environment:
  - Enhancing the adoption of “new” knowledge
  - Innovations
  - Regional CME
- Research
  - Care initiatives
  - Other research

Illustrative Pro Forma and Summary

To illustrate how this may come together:

Family Medicine
DRAFT GME Pro Forma

	Start-up Phase		Residency Training						
Number of Claimed Residents			**4.00**	**8.00**	**12.00**	**12.00**	**12.00**	**12.00**	**12.00**
Reimbursement	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**	**Year 8**	**Year 9**
IME Hospital A	$ -	$ -	$ 252,424	$ 419,676	$ 669,042	$ 669,042	$ 669,042	$ 669,042	$ 669,042
IME Hospital B			1,575	25,378	25,378	25,378	25,378	25,378	25,378
DGME Hospital A			99,342	167,225	270,236	272,939	275,668	278,425	281,209
DGME Hospital B			39,740	141,016	181,103	182,660	184,233	185,822	187,426
Other funding, e.g. Clinics, grants	375,000	375,000	-	-	-	-	-	-	-
Total Reimbursement	**$ 375,000**	**$ 375,000**	**$ 393,081**	**$ 753,296**	**$ 1,145,760**	**$ 1,150,019**	**$ 1,154,321**	**$ 1,158,667**	**$ 1,163,055**
Expenses									
Salaries									
Resident Salary	$ -	$ -	$ 214,000	$ 444,960	$ 693,829	$ 714,643	$ 736,083	$ 758,165	$ 780,910
Resident Benefits @ 29%	-	-	62,060	129,038	201,210	207,247	213,464	219,868	226,464
Physician Salary & Benefits	288,176	384,235	338,237	417,050	530,262	546,169	562,555	579,431	596,814
Other Administrative Salaries	52,245	58,050	136,000	140,080	144,282	148,611	153,069	157,661	162,391
Total Salaries and Benefits	**$ 340,421**	**$ 442,285**	**$ 750,297**	**$ 1,131,129**	**$ 1,569,583**	**$ 1,616,670**	**$ 1,665,171**	**$ 1,715,126**	**$ 1,766,579**
Other Than Salary									
Insurance Premiums	$ -	$ -	$ 4,000	$ 8,944	$ 15,277	$ 15,735	$ 16,207	$ 16,694	$ 17,194
Didactic/Lectures			19,500	20,085	20,688	21,308	21,947	22,606	23,284
Accreditation/Program Approval Fees		6,200	5,200	5,356	5,517	5,682	5,853	6,028	6,209
Professional Fees	50,000	50,000	6,000	12,360	19,096	19,669	20,259	20,867	21,493
Recruiting Expenses	50,000	75,000	8,000	16,000	24,000	24,000	24,000	24,000	24,000
Resident Affairs			4,000	8,240	12,731	13,113	13,506	13,911	14,329
Capital expenditures	250,000	275,000	-	-	-	-	-	-	-
Clinic Lease	tbd	tbd	-	-	-	-	-	-	-
Supplies and Misc. Expenses		125,000	60,000	123,600	190,962	196,691	202,592	208,669	214,929
Total Other Than Salary	**$ 350,000**	**$ 531,200**	**$ 106,700**	**$ 194,585**	**$ 288,270**	**$ 296,198**	**$ 304,364**	**$ 312,775**	**$ 321,438**
Total Direct Expenses	**$ 690,421**	**$ 973,485**	**$ 856,997**	**$ 1,325,714**	**$ 1,857,853**	**$ 1,912,869**	**$ 1,969,535**	**$ 2,027,901**	**$ 2,088,018**
Direct Contribution Margin	**$ (315,421)**	**$ (598,485)**	**$ (463,916)**	**$ (572,418)**	**$ (712,093)**	**$ (762,849)**	**$ (815,213)**	**$ (869,234)**	**$ (924,962)**

How can some of the residual benefits of GME offset Medicare funding shortfalls?

Number of Claimed Residents			**4.00**	**8.00**	**12.00**	**12.00**	**12.00**	**12.00**	**12.00**
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**	**Year 8**	**Year 9**
Claimed Residents			**4**	**8**	**12**	**12**	**12**	**12**	**12**
Reimbursement									
Total IME per FTE	$ -	$ -	$ 63,500	$ 55,632	$ 57,868	$ 57,868	$ 57,868	$ 57,868	$ 57,868
Total DGME per FTE	-	-	34,770	38,530	37,612	37,967	38,325	38,687	39,053
Total Other Reimbursement per FTE	-	-	-	-	-	-	-	-	-
Total Estimated Reimbursement Per FTE	**$ -**	**$ -**	**$ 98,270**	**$ 94,162**	**$ 95,480**	**$ 95,835**	**$ 96,193**	**$ 96,556**	**$ 96,921**
Total Estimated Direct Expenses per FTE	**$ -**	**$ -**	**$ 214,249**	**$ 165,714**	**$ 154,821**	**$ 159,406**	**$ 164,128**	**$ 168,992**	**$ 174,001**
Variance per FTE			**$ (115,979)**	**$ (71,552)**	**$ (59,341)**	**$ (63,571)**	**$ (67,934)**	**$ (72,436)**	**$ (77,080)**
Estimated Offsets Per resident									
Recruitment cost savings			$ -	$ -	$ -	$ 8,333	$ 8,583	$ 8,841	$ 9,106
Clinical extender cost savings			-	-	11,550	11,897	12,253	12,621	13,000
Resident productivity/volume impact			-	-	15,976	16,455	16,949	17,457	17,981
Sponsoring Institution In Kind			7,500	7,500	7,500	7,500	7,500	7,500	7,500
Medicaid per Resident			27,405	27,405	27,405	27,405	27,405	27,405	27,405
State Educational Grant Support			5,000	5,000	5,000	5,000	5,000	5,000	5,000
Total Estimated Offsets per Resident			**$ 39,905**	**$ 39,905**	**$ 67,431**	**$ 76,590**	**$ 77,690**	**$ 78,824**	**$ 79,991**
Net Impact of Offsets			**$ (76,074)**	**$ (31,647)**	**$ 8,090**	**$ 13,019**	**$ 9,756**	**$ 6,388**	**$ 2,911**

Some summary thoughts:

- How we value residency training, and the role it plays at our organizations and in our communities, needs to be well understood.
  - Beyond DME and IME.
  - Varies from site to site and from program to program, but nonetheless needs to be quantified.
- Our assessment of this value will better enable us to be proactive vs. reactionary and short-sighted.
- Given the required investment in GME, it may make sense to consider ways to better collaborate, formally or informally.

Though GME economics and the costs to sustain residency training are important, we cannot forget the educational component and how this may enhance or limit our ability to meet future hospital, community and workforce needs.

PKFHealth, LLC

- National consulting firm
- Work with all types of hospitals, medical schools and consortiums
- GME feasibility work and implementations
- Analysis of legacy programs
- Medicare appeals and audits
- Consortium development (Centralized GME Office, CA, MI, NY, FL, CT, OK)
- Served as expert consultant to HRSA on THCs
- Work with rural sites and RTT development (MT, VT, OH, NY)

Questions and Answers

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