

# Financing Innovation in GME

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## Overview

- ♦ Training-practice gap is widening
- ♦ GME funding structure as an obstacle to innovation
- ♦ Challenges facing teaching hospitals
- ♦ Can we negotiate?

## The Training-Practice Gap



## Evidence of a Training-Practice Gap

- ♦ Dated Educational Paradigm
- ♦ Ecology of Medical Care
- ♦ Empiric evidence
  - ♦ Survey data

## Dated Educational Paradigm

- ♦ Skills mastered in the care of complex inpatients readily transferred to the care of outpatients with similar conditions
- ♦ Patients requiring care of multiple disciplines or complex medication adjustments hospitalized
- ♦ All problems fully managed and stabilized prior to discharge

## Dated Educational Paradigm

- ♦ Dramatic shift in health care delivery
  - ♦ Increasingly complex care provided in outpatient settings
  - ♦ Increased barriers to hospitalization and hospitalized patients discharged with unresolved issues
  - ♦ Systems developed to support complex outpatient care
    - ♦ EMR
    - ♦ Same-day appointments
    - ♦ Group visits
    - ♦ Interdisciplinary chronic care models
    - ♦ Continuous practice monitoring systems
- ♦ No comparable shift in the educational paradigm or GME funding

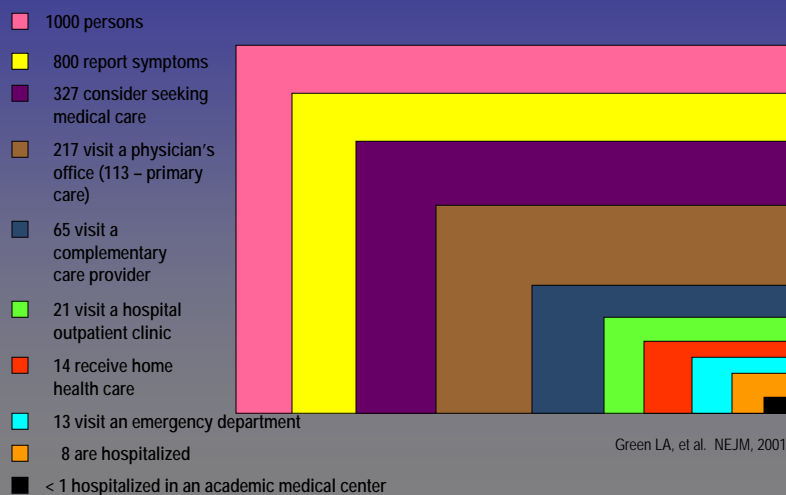
## Ecology of Medical Care

- ◆ Relationships between people and their health care environments
- ◆ Conceptualized > 40 years ago to guide thinking about the organization of health care
- ◆ Depicts the proportion of persons using health care services in particular settings in an average month

## Ecology of Medical Care

- ◆ Updated by LA Green, et al in 2001
- ◆ Data derived from 1996 Medical Expenditure Panel Survey and a nationally representative telephone survey conducted by Gallop, staggered for seasonal variation
- ◆ Estimated the number of persons/1000 who experience specific health care events during a one-month period

## Ecology of Medical Care



## Survey Data

- ♦ 1993: Cantor, et al
  - ♦ 80%: medical education did a "good" or "excellent" job of training them for clinical practice
  - ♦ Family medicine, GIM and Psychiatry least satisfied
  - ♦ Areas of concern: treating patients with disabilities, geriatric care, coordinating care with community services, providing cost-effective care, and practice management
- ♦ 2001: Blumenthal, et al
  - ♦ >10% of residents in each specialty reported feeling unprepared to manage one or more tasks related to their discipline
  - ♦ 11% of IM residents felt prepared to participate in QI activities and care for populations of patients
  - ♦ Areas of concern: care of depression, geriatric care, chronic disease care

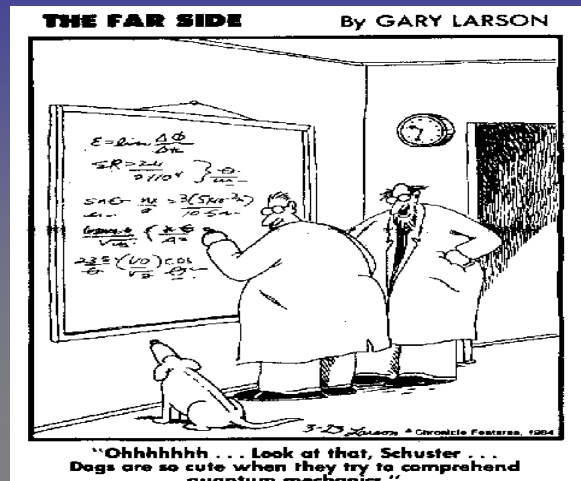
## Survey Data

- ♦ 2003: Girard, et al
  - ♦ Residents in primary care disciplines felt less competent than residents in all other specialties
- ♦ 2004: Partnership for Solutions
  - ♦ 2/3 reported that their training had not prepared them to coordinate care or educate patients with chronic conditions
- ♦ 2006: Mueller, et al
  - ♦ New internal medicine faculty rated the adequacy of their communication training significantly lower than the importance of those skills to clinical practice

## Summary of Survey Data

- ♦ Adequate knowledge to pass board examinations
- ♦ Mismatch between knowledge/skills tested and healthcare issues most likely to encounter
- ♦ Poorly prepared for the real-world practice environment

# GME Funding Structure as an Obstacle to Innovation



## GME Funding Structure

- ♦ Sources of GME Funding: ~ \$ 15 billion/year
  - ♦ Medicare: > 70% of all GME funding
    - ♦ DGME: ~ \$2.4 billion
    - ♦ IME: ~ \$5.8 billion
  - ♦ Medicaid: ~ 3.2 billion
  - ♦ Non-Medicaid State \$\$: ~ 2 billion
  - ♦ VA: ~ \$850 million
  - ♦ DOD: ~ \$380 million
  - ♦ Misc: ~ \$500 million
  - ♦ Private insurers: (?) ~ 7 billion

> \$150,000/resident/year

## Medicare Funding of GME

- ◆ DGME: ~ \$2.4 billion
  - ◆ Per resident amount (PRA)
  - ◆ Based on 1984 reported GME costs/resident
  - ◆ Salaries and fringe benefits
  - ◆ Teaching physician time
  - ◆ Overhead and administrative costs
- ◆ IME: ~ \$5.8 billion
  - ◆ Higher hospital costs due to presence of residents and greater patient complexity not captured by DRG system
  - ◆ Percent increase paid per Medicare discharge
    - ◆ 11.1% → 5.5%
  - ◆ Based on resident/bed ratio → BBA cap on # residents

## The Devil in the Details

- ◆ DGME PRA set in 1984
  - ◆ Hospital-specific
  - ◆ Highly variable across hospitals
    - ◆ Range: \$33,000 - \$155,000
- ◆ Medicare share variable across hospitals
- ◆ Allowable for FTE resident count
  - ◆ % of time on inpatient services subject to PPS
  - ◆ % of time spent on hospital outpatient service
  - ◆ Recent changes to avoid paying for didactic time
- ◆ How much is coming into your institution?
  - ◆ Graham Center web site: [www.graham-center.org](http://www.graham-center.org)

## Obstacles to Educational Innovation

- ♦ GME funding is Medicare/Medicaid dependent
  - ♦ Financial incentives to assign residents to inpatient services and hospital-based outpatient clinics
  - ♦ Continually at risk
    - ♦ IME schedule of decreasing payments
    - ♦ Changing rules on FTE count to reduce payment for didactic time
    - ♦ New rules eliminate federal matching funds for Medicaid GME

## Obstacles to Educational Innovation

- ♦ Funding goes to teaching hospitals
  - ♦ System characterized by cross-subsidies among components and missions
  - ♦ Culture of secrecy around GME funds
- ♦ DME and IME bundled into DRG inpatient payments
  - ♦ Entered as general operating revenues
  - ♦ No accountability for how funds spent
  - ♦ No link to national workforce policy → training a workforce for tertiary care hospitals

## Costs of Educational Change

- ◆ Losses in reimbursement
- ◆ Replacement costs
  - ◆ Resident service responsibilities
  - ◆ Resident teaching responsibilities
- ◆ Teaching costs
  - ◆ Expanded and more diverse curriculum
  - ◆ Outcomes assessment
  - ◆ Greater faculty supervision
  - ◆ More faculty development

## Challenges Facing Teaching Hospitals



## Historical Perspective

- ◆ Pre-1980's
  - ◆ Indemnity insurance and cost-plus reimbursement environment
  - ◆ Competition along non-price dimensions
    - ◆ Competed for physicians and patients
    - ◆ Highly specialized, inpatient clinical services
    - ◆ "Hotel-like" features and amenities
    - ◆ Hospitals began advertising to build brand name image and loyalty
  - ◆ "Medical Arms Race"

## Historical Perspective

- ◆ 1980s and 1990s
  - ◆ Sky-rocketing healthcare costs
  - ◆ Market and policy responses
    - ◆ Medicare Prospective Payment System
      - ◆ Pre-set reimbursement per DRG
    - ◆ Managed care
      - ◆ Induce price competition
      - ◆ Slow the rate of adoption of new technology
    - ◆ Balanced Budget Amendment 1996
      - ◆ Further cuts in Medicare reimbursement
  - ◆ Slowed the "Medical Arms Race"

## Historical Perspective

- ◆ 1980s and 1990s
  - ◆ Impact on teaching hospitals
    - ◆ Suffered huge financial losses
      - ◆ Headlines
        - ◆ "Deep Medicare Cuts Draw Blood at Teaching Hospitals" Crain's Chicago Business
        - ◆ "Four Hub Teaching Hospitals Awash in Red Ink" Boston Herald
    - ◆ New type of hospital CEO
    - ◆ Increased price competition to attract HMOs
    - ◆ Hospital consolidations and organized delivery systems to cut costs

## Historical Perspective

- ◆ 1980s and 1990s
  - ◆ Impact on teaching hospitals
    - ◆ Expansion of primary care
      - ◆ Reduce hospitalizations
      - ◆ "One-stop-shopping"
    - ◆ Reduction of inpatient beds
    - ◆ Departments contracted
      - ◆ Protected research time and start-up funds declined
      - ◆ Increased productivity demands

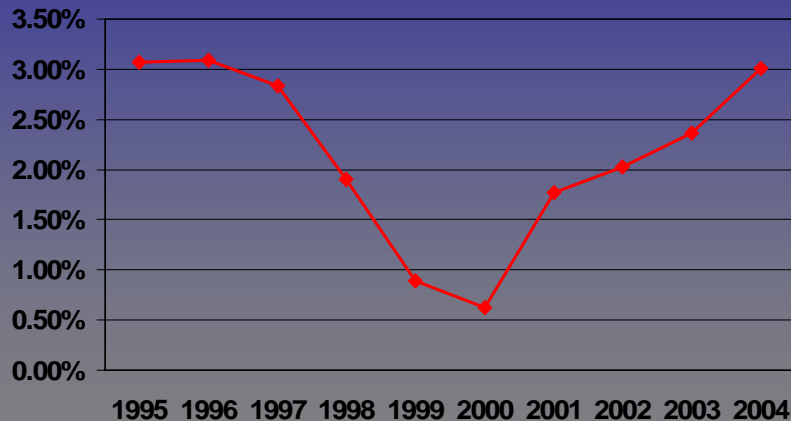
## Historical Perspective

- ◆ 2000 →
  - ◆ Backlash against HMOs
    - ◆ Enrollment declined
    - ◆ Negotiating leverage declined
  - ◆ Teaching hospitals returned to competing for physicians and patients
    - ◆ Building boom
      - ◆ 1996: \$30 billion → 2004: \$67 billion
      - ◆ New specialty hospitals and services
        - ◆ Women's health care centers
        - ◆ Cardiac hospitals
        - ◆ Oncology centers

## Historical Perspective

- ◆ 2000 →
  - ◆ Teaching hospitals returned to competing for physicians and patients
    - ◆ Expansion of inpatient subspecialty services that generate highest revenues
      - ◆ Primary Care deemphasized
      - ◆ Growth in subspecialty faculty and higher salaries to reduce competition
    - ◆ Shift in BBA fixed number of residency/fellowship spots
      - ◆ 1999 → 2004: 6.5% decrease in PGY-1 positions
      - ◆ 14.3% increase in fellowship positions

## Median Operating Margins for COTH Hospitals



## The "New" Medical Arms Race?

- ◆ Competitive strategy
  - ◆ First on the block with the newest technology and best amenities
    - ◆ Market share for most profitable services
    - ◆ Monopoly pricing
- ◆ 15 New Medical Schools
  - ◆ With new teaching hospitals and/or biotech centers
- ◆ 2007 AAMC Report: Medical Schools, Teaching Hospitals are Major Economic Engine
  - ◆ > 1.6 million jobs
  - ◆ \$451.6 billion economic impact in 2005
- ◆ Many economists predict health care will become driving force of the economy, reaching 25% of GDP by 2030

## Can We Negotiate?



## Financing Educational Innovation

- ♦ Good News
  - ♦ Teaching hospitals more profitable
- ♦ Bad News
  - ♦ Fragile public support for sustained/additional funding
    - ♦ Teaching hospitals more profitable
    - ♦ Record federal deficit
    - ♦ Medicare goes broke in 2019
    - ♦ No obligation to address workforce needs in exchange for public monies
    - ♦ Training physicians as a "public good" vs subsidizing the education of elite professionals

## Can We Negotiate?

- ◆ CEOs less likely to be physicians and from academic world
  - ◆ Primary responsibilities
    - ◆ Fiduciary
    - ◆ Distinguishing the institution
    - ◆ Increasing market share
  - ◆ Benefits of good education and research not intuitive

## Can We Negotiate?

- ◆ CEOs believe education to be the department's responsibility
  - ◆ Understanding of GME
    - ◆ Substantial, but threatened, revenues from public funding
    - ◆ Inexpensive labor force
    - ◆ Education model: Learning by doing
    - ◆ Violating RRC requirements a problem
  - ◆ No reason to believe that the funding is inadequate

## What not to say.....

- ◆ "This is your responsibility."
- ◆ "You're making it impossible for me to do my job."
- ◆ "You have to do this to fulfill the hospital's mission."
- ◆ "You're making lots of money. So, what's the problem?"

## Strategy to fund change

- ◆ Understand your hospital's financial situation and the flow of education funds
- ◆ Beyond earmarked education funds:
  - ◆ Understand hospital's strategic plan
  - ◆ Understand priority initiatives
  - ◆ Align educational needs with strategic plan
    - ◆ How does this educational program fit into the hospital's priorities and strengthen the institution
  - ◆ Speak their language and develop a relationship
  - ◆ Have a business plan

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## Better language....

- ◆ "I understand that you have a quality initiative. I would like to know how the educational program can help."
- ◆ "I'd like to talk about how the IM program can participate in the hospital's new safety program."
- ◆ "How can I help to align the hospital's priorities with our educational goals?"

## Financing Innovation in GME

