ACADEMIC CONSULTING ADVISORS

GME GRADUATE MEDICAL EDUCATION

IMPROVING GME ECONOMICS

Academic medical centers and teaching hospitals, with their education, research, and patient-care missions, are highly complex and interconnected organizations. These institutions face a rapidly changing healthcare environment that pressures GME programs as they continue their mission to train highly qualified residents. Although most reimbursement and costs associated with GME programs are fixed, with minimal opportunity for improved financial performance, there are several areas that can improve financial metrics. Managing these academic variables is essential to maintaining quality programs that are also fiscally responsible.

AMBULATORY TRAINING

The clinical training component of resident education often represents the single largest manageable cost variable in GME economics. A superior outpatient teaching experience can include operational efficiencies while complying with the accreditation requirements established by the ACGME and enhancing program quality. Structuring clinic operations based on these variables will improve economics and provide a vehicle to improve access to the medically underserved community.

Traditional hospital and medical practice management metrics are relevant to teaching clinics, but additional tools and approaches are required to address the added complexity of resident training. Isolating and differentiating the faculty time spent in private practice, teaching clinics, and other responsibilities such as inpatient service, hospital directorship, or administration is critical to establishing baseline metrics.

The primary care exception rules enable faculty members to precept up to four residents at a time. With the use of faculty and resident schedules, patient billing information, and medical records data, required faculty time and effort can be accurately tracked and managed.

FQHC COLLABORATION

Many organizations supporting primary care residency programs are taking a different approach. These organizations have transitioned their continuity clinic training requirement to affiliated Federally Qualified Health Centers (FQHC) or other community supported organizations. This collaboration can provide multiple advantages including expanding the delivery capacity of the FQHC through integration with the teaching program. The integrated entity receives higher reimbursement and access to grant funding. If structured appropriately; this strategy can increase delivery capacity to medically underserved areas while improving the economics for both entities. The existing patient panel also represents an ideal training experience for primary care residents.

MAXIMIZE REIMBURSEMENT SOURCES

The complexities of GME reimbursement, coupled with ever-evolving regulations, have created challenges and opportunities for teaching hospitals. GME reimbursement methodologies contain many variables that may fluctuate the hospital's GME reimbursement year over year. Both short and long-term strategies can be implemented to improve program economics.

RURAL RECLASSIFICATION

By reclassifying a hospital from urban to rural, the hospital can increase its 1996 IME cap by 30%. In addition, a rural hospital may start new GME programs not subjected to the previous cap limits.

BED REDUCTION OPPORTUNITIES

Beds available count is a critical driver of IME payments. Licensed beds, which are typically used, are often greater than beds in service, resulting in lower reimbursement to the hospital.

AFFILIATION AGREEMENTS

Create GME agreements with affiliated hospitals to share cap space between those under the cap with those over the cap.

NON-PROVIDER ROTATIONS

Leverage the varying reimbursement levels in a health system to allow a teaching hospital not limited by GME cap limits to claim those residents for non-provider rotations.

PROGRAM COST REPORTING AND STRUCTURE

The cost to support GME training and reporting of these costs varies significantly across academic medical centers and teaching hospitals due to inconsistent cost reporting practices and variations in the size and types of GME programs. At ACA, we find that applying ACGME requirements, which are generally standardized by specialty, can provide a target for anticipated cost. By creating this baseline target, unique program characteristics can be identified and integrated into the modeling. Understanding and tracking these metrics can highlight potential areas for further investigation and serve to establish consistent metrics to evaluate programs and frame ongoing strategic investment. Strategic considerations could include medical school/community partnerships, FQHC alignment, GME rightsizing, and improved resource allocation/legacy financial agreements.

CONCLUSION

ACA leaders deeply understand the strategic investment of limited resources and funding available to academic medical centers and teaching hospitals to achieve their missions and visions. Understanding the various stakeholder perspectives within this environment enables us to gain credibility with decision-makers and manage competing objectives. Our experts have dedicated their careers to assisting hospitals, healthcare systems, physician medical practices, and medical schools' leadership in navigating and managing the complexities of the GME enterprise. We understand the high-stakes decisions that must be made when preparing complex academic enterprises for the future, and we are skilled at finding approaches that build consensus and support for both small and large-scale change.