REDEFINING THE GME EXPERIENCE

germane solutions

THOMAS P. MILLER & ASSOCIATES

Proposal for Indiana Graduate Medical Education Board

2016 | May 17| Indianapolis, IN

May 17, 2016

Agenda

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Introductions – Project Team

Project Leadership

Art Boll, CEO
Germane Solutions - Engagement Partner and Project Leader

Project Management

Jake Jedynak, Manager
Germane Solutions - Project Manager and Operations Lead

Mary Jane Michalak, Vice President
TPMA - Project Manager

Frank Keeling, Manager
Germane Solutions - Project Manager and Finance Lead

Specialized Capabilities

Mark Simonson, Vice President
Germane Solutions – Reimbursement & Finance

Justin Heet, Assistant Director
TPMA – Economic Analysis

Joseph Catanese, MHA, Manager
Germane Solutions - Accreditation

Zach Leahy, Consultant
Germane Solutions - Finance

Neil Metzger, Project Assistant
TPMA – Economic Analysis Specialist

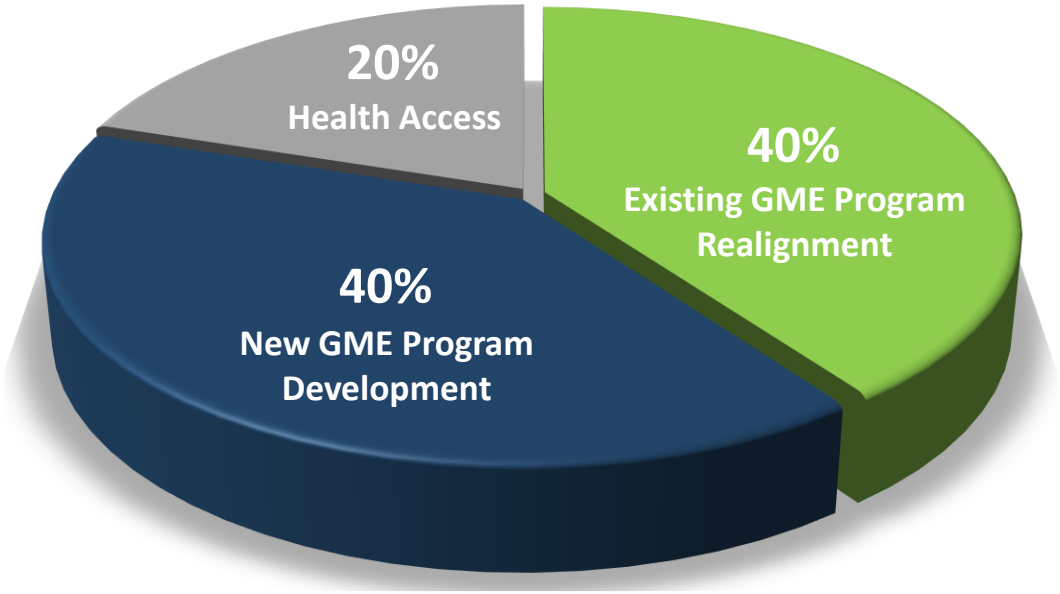
Introductions – Germane Solutions

- Germane Solutions is a national, niche healthcare consulting/technology firm that specializes in all aspects of Graduate Medical Education (GME). We have assembled a team of subject matter experts with a broad range of knowledge on every aspect of GME.
- We have completed over 200 GME engagements and we have worked with 85 hospitals helping them to become teaching hospitals over the past 5 years

All Clients Over Last Five Years (2011-2016)

Germane Solutions is uniquely positioned to assist the Indiana Graduate Medical Education Board in achieving their objectives

- Germane specializes in all phases of GME, and derives the majority of its revenues from assisting new program development and realigning existing GME programs to meet organizational goals
- 15% of our total revenues are reinvested into technology solutions and research for all three divisions to improve our ability to analyze and improve residency training programs



Thomas P. Miller & Associates

- **Based in Indianapolis** – accessible throughout the duration of the project, go-to Project Manager (Mary Jane Michalak)
- **Familiarity with Indiana** – know state and regional workforce, education, and economic development priorities
- **Comprehensive, sound approach to economic impact analysis** – worked with Indiana State University, Purdue, Ohio University, etc.
- **Healthcare-related projects in Indiana** – IU School of Nursing,

School of Health and Rehabilitation Sciences, Rural Health Innovation

Collaborative (RHIC)

- **Experience in 40 states nationwide and has assisted hundreds of clients**

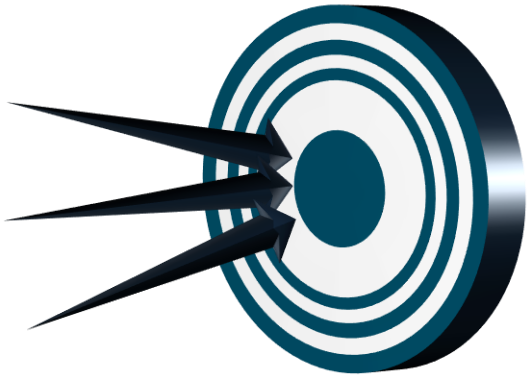
NEEDS ASSESSMENT/NEW GME PROGRAM DEVELOPMENT

Needs Assessment – Green Field Assessment

- When assessing the potential for large scale expansion of GME, we will utilize a "green field" analysis that encompasses all eligible sites for GME.
- For all non-teaching hospitals in the State we will perform a comprehensive assessment of GME potential.

Key Variables for Medicare GME Reimbursement

- ✓ Medicare Utilization
- ✓ DRG & Outlier Payments (Capital DRG)
- ✓ Medicare Managed Care Payments
- ✓ Available GME Beds
- ✓ Bed Occupancy %
- ✓ Case Mix & Discharges
- ✓ FTE Counts & Caps (Teaching)



Non- Teaching Hospitals

- Estimated GME Reimbursement Potential
- Projected Resident Counts and Caps
- What type of programs they have the ability to support
- Potential opportunity to increase GME reimbursement (available beds, etc.)

Teaching Hospitals (Opportunistic)

- Current GME Reimbursement
- Current FTE Counts & Caps Difference
- Potential changes to current operations (FTE counts, # of available beds, etc.)
- Potential cost reporting errors, unclaimed funds

Needs Assessment – Green Field Assessment

- The largest new development area for new GME programs is with community hospitals. While not as resource rich as large academic institutions, they are attractive sites for new GME program development (particularly for primary care);
- Based on the current CMS regulations, most hospitals within the State fall into 4 categories relative to GME developmental potential:

Hospital Type	Acute Care Hospitals	Critical Access Hospitals	Sole Community Provider Hospitals	Medicare Dependent Hospitals
Key Characteristics	Hospitals operate under Prospective Payment System (PPS) from Medicare	Be located in a Medicare designated "rural" area and/or meet other Medicare Conditions of Participation	Hospitals located at least 35 miles from "other like hospitals"	Hospital located in a rural area w/ fewer than 100 beds and participates in Medicare IPPS
GME Impact	Assuming no previous GME activity, they are eligible to receive both DME and IME funding from Medicare	Are not eligible to receive IME payments	To be eligible for GME, SCH payments must be lower than potential IPPS payments	To be eligible for GME, MDH payments must be lower than potential IPPS payments

Primary Focus

Secondary Focus

Needs Assessment – Green Field Assessment

- Based on an initial analysis, 14% of all hospitals in the State of Indiana are teaching hospitals and 86% of the hospitals are non-teaching hospitals
- Of the 147 non-teaching hospitals, our focus will be on the approximately 47 hospitals with more than 50 beds, as they are more likely to have the resources necessary to support GME programs, either independently or as part of a GME Consortium.

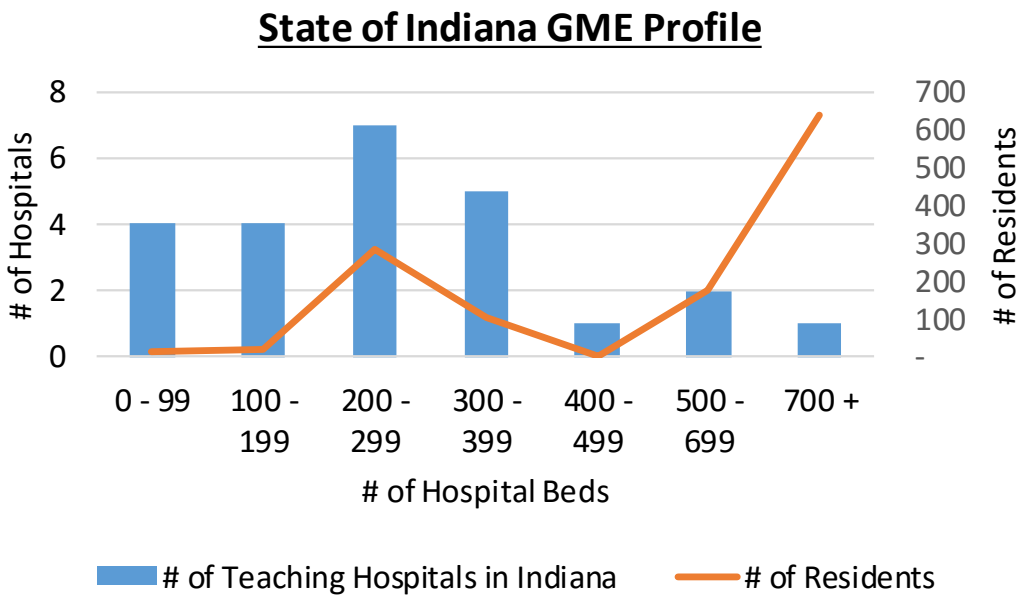
State of Indiana GME Profile		Urban	Rural	Psych	Total	% of Total
Teaching Hospitals	Less Than 4 Residents	9	0	0	9	5%
	More Than 4 Residents	15	0	0	15	9%
	Sub-Total	***24***	***0***	***0***	***24***	***14%***
Non-Teaching Hospitals	Less Than 50 Beds	55	43	2	100	58%
	More Than 50 Beds	38	9	0	47	27%
	Sub-Total	***93***	***52***	***2***	***147***	***86%***
	Total	***117***	***52***	***2***	***171***	***100%***

Non-Teaching Hospitals - More than 50 Beds			
Non-Teaching Hospitals	Sole- Community Providers & CAH	3	6%
	Urban	38	81%
	Rural	6	13%
	Total	***47***	***100%***

Leading hospital candidates for developing new GME programs

State of Indiana GME Profile

- Currently, there are 24 teaching hospitals within the State of Indiana
- The 24 teaching hospitals train approximately 1,240 residents, with over half of those residents training within one health system (Indiana University Health)
- By expanding GME development to community hospitals, Indiana could significantly increase the number of teaching hospitals with less than 200 beds



# of Hospital Beds	# of Teaching Hospitals in Indiana	# of Residents
0 - 99	4	13
100 - 199	4	17
200 - 299	7	283
300 - 399	5	105
400 - 499	1	3
500 - 699	2	178
700 +	1	642
Total	**24**	**1,240**

Needs Assessment – Green Field Assessment

- Since so much of the existing GME is concentrated in a small number of hospitals and accredited sponsors, expanding GME within the State may require new models to maximize the value of the available resources

Individual Sponsorship Scenario:

- Hospital owns programs and the CMS resident cap
- GME "learning curve" can be steep
- Total transparency of program operations and strategy
- Total responsibility for all costs and risks of the programs
- High long-term reward (3+ years)
- High initial risk and upfront costs (Initial 2 years)

Medical School Scenario:

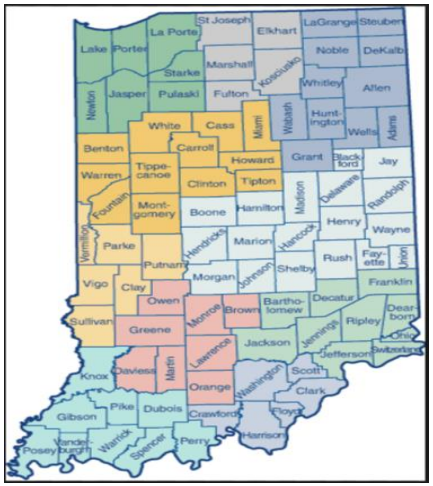
- Medical School bears all direct cost of residents
- High likelihood of initial success
- Hospital does not have a strong negotiating position
- Programs likely to have high academic quality
- Likely expensive in the long term
- Lowest initial risk for program start up

Consortium Sponsorship Scenario:

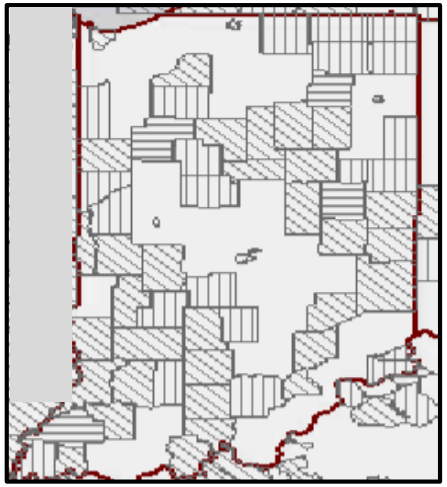
- Will need to submit an IRD to ACGME before accreditation
- Maximum flexibility across multiple partners
- Collaborative model
- Best leverage of program leadership
- Politically complicated, trust dependent
- Requires strong leadership and operating agreements

Needs Assessment – State Wide Impact

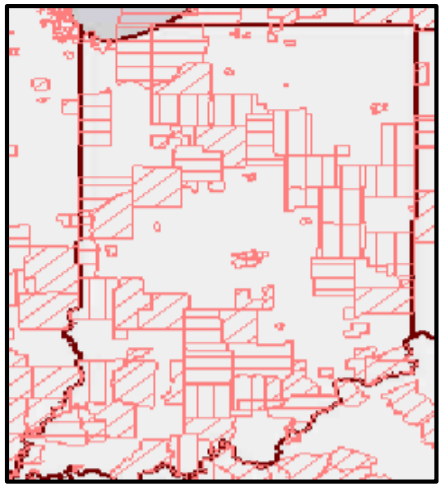
- We will incorporate our new GME development findings within a state wide assessment that will determine the potential clinical and economic development across the state, with a particular focus on the impact on the large number of underserved areas within the state



Area/County Development



HPSAs within IN



MUAs within IN

- **Build out immediate impact by host communities for residency programs utilizing**:
  - Operational and capital budgets for each new teaching hospital
  - Spending of residents/medical students within the community
  - Long-term benefits on student's lifetime earnings in Indiana
  - Spending of affiliated/auxiliary enterprises
  - Visitors to the teaching hospital
- **Utilization of Economic Modeling Specialists, Intl. (EMSI) data –** provide regional customization and greater degree of industry specificity

Needs Assessment – Economic Assessment

- New GME programs and expanding of current GME programs will have a positive economic impact for the State of Indiana.
- The impact can be significant on a State-wide basis depending on the number of new residency program that are created and established.
- We will develop an overall potential economic impact based on viable GME program sites.

18 Person Family Medicine Residency Program

Number of People

Faulty	Residents	Program Personnel	Clinical Support	Total
5	18	5	18	46

Revenues

GME Reimbursement	Clinical Professional Fees Revenues	Total
$ 2,340,000	$ 1,625,000	$3,965,000

x

Total Non-Teaching Hospitals with > 50 Beds and That Are Not SCH or CAH
44

Direct Economic Impact

↓

Downstream Economic Impact

↓

Total Expected Economic Impact

Typical # of Programs per Hospital – 2 -3 Programs

- Illustrative example of one family medicine residency program and the amount of Medicare revenues that could be received
- There are 44 hospitals in Indiana where 1-3 GME program may be viable

FISCAL IMPACT/EXPANSION OF GME

Fiscal Impact – GME Programs Potential and Direct Economics

- If there are existing hospitals/programs within the State that are interested in expanding their existing GME programs, they will likely have to undertake this expansion without the benefit of Medicare GME reimbursement
- However, there are number of ways in which the programs can potentially support GME expansion including maximizing existing GME reimbursement and by improving the overall clinical operations against industry benchmarks

Utilizing Medicare Cost Reports

- Identify overall GME costs
- Develop strategies to maximize GME reimbursement across entire health network

Outcome

- Increased funding and potentially reduced the need to scale back GME

Utilize GME Benchmarks

- Integration of PROMPT with clinical activities
- Manage clinical expectations

Outcome

- Evaluate current GME program costs against GME benchmark costs

Utilizing PROMPT

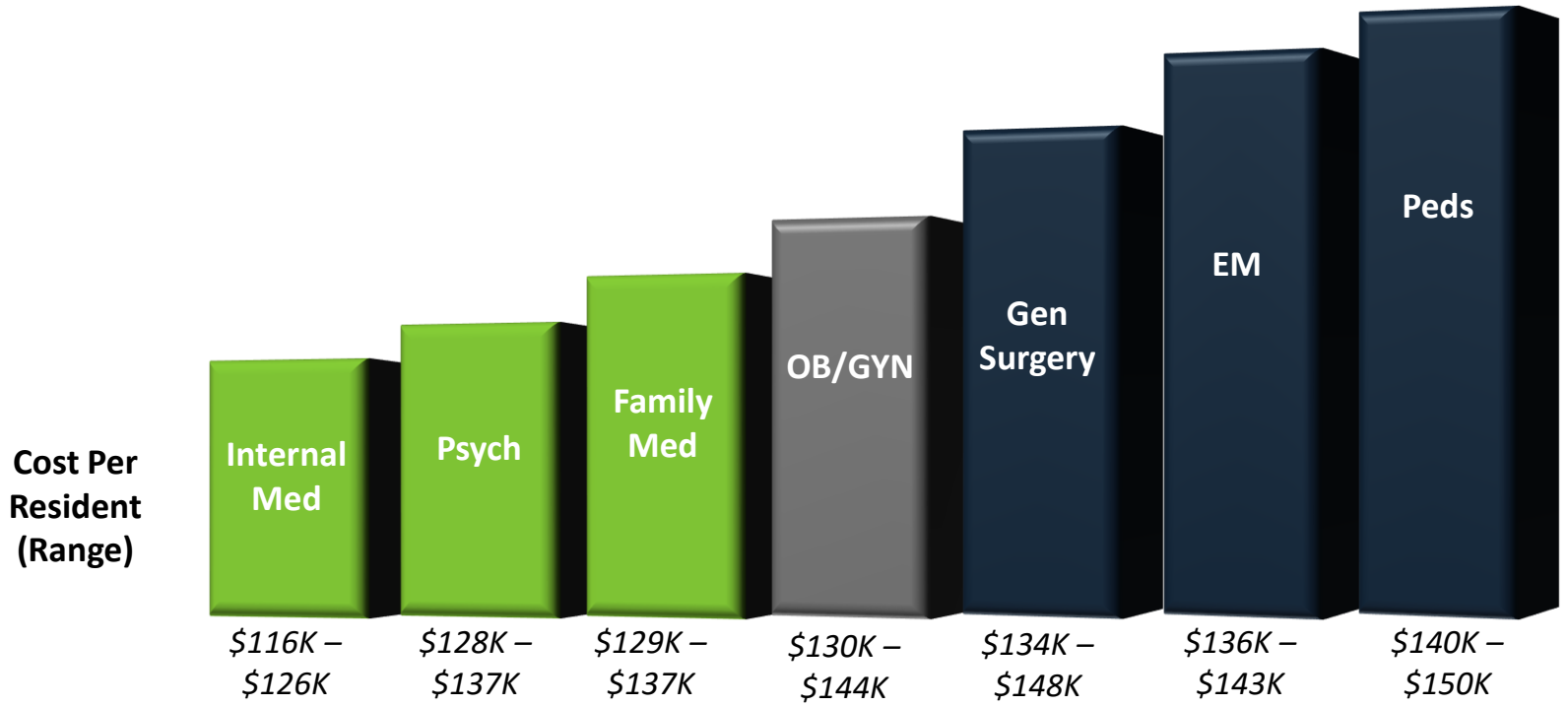
- Analysis of clinical operations efficiency and effectiveness
- Define the clinical "benefit" and cost model of each program

Outcome

- Clinical training information to provide insight on program value and training performance

Fiscal Impact – GME Program Cost Benchmarks

- Germane has the real word data necessary to provide the Board with supportable financial benchmarks for cost of operating multiple types of GME programs
- Program sizing will be a key consideration when determining program cost as many programs have a high level of fixed costs that can be reduced with increased size

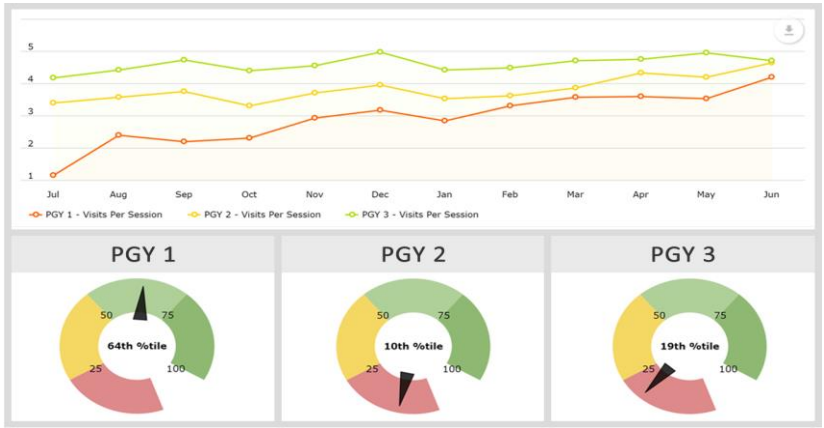


Fiscal Impact – Clinical Revenues

- Some teaching hospitals have opted to support GME development/expansion through clinical revenues generated by the GME programs
- For this strategy to be effective, the GME programs must be appropriately sized relative to coverage/service provided as well as have the resident be effectively leveraged throughout their training
- Germane's PROMPT tool can provide hospitals the clinical insight needed to determine if funding GME from clinical revenues is a viable option

Identify High Impact Areas of Improvement

Track Compliance/Performance



Identify Opportunities and Incentives

Improvement Area		Metric	Explanation / Approach to Achieve Improvements	Current Value	Target	Annual Impact
Structured Improvement Activity 1	Templates	Visits per Session - Faculty	Modify templates to increase access and throughput	4.4	10	$92,990
	Templates	Visits per Session – Residents	Modify templates to increase access and throughput / prepare residents for private practice	5.2	6	$158,340
	Templates	Visits per Session - NPs	Modify templates to increase access and throughput	5.3	7	$230,120
	Total - Template Modifications					**$481,450**

Fiscal Impact – Alternatives to Traditional Medicare GME Funding

- In addition to funding programs through clinical revenues, there other options to help fund GME development/expansion that do not rely solely on traditional Medicare GME funding

Alternatives for GME Development

Non-Traditional Medicare Funding

- **Rural Track Residency Programs –** Allows for expansion of hospitals resident cap if program develops rural training site
- **Non Approved Programs** - Non ACGME approved programs can be developed and receive cost based reimbursement to support the programs

HRSA and Other Federal Funding

- **Primary Care Training and Enhancement Grant –** Provides up to $250,000 in funding for the training of primary care providers – funding doubles if partnering with FQHC or other non-profit entities
- Teaching Health Center Grant - Hopefully Congress will authorize the renewal of the THCGME grant which allows FQHCs to sponsor/fund GME programs

For Profit Funding

- **International Medical Schools** –Int. medical schools are funding the GME programs in order to secure long term UME clerkships training locations
- **National Physician Groups** - Highly productive specialty physician groups (Radiology, Anesthesiology, etc.) are funding GME programs in order take advantage of low cost resident leverage

Non-Profit Funding

- **Charity or Foundation Funding –** Many large foundations can contribute to the development of GME as part of their mission. While some are state based, there are other that have a more national focus (such as the Osteopathic Heritage foundation)

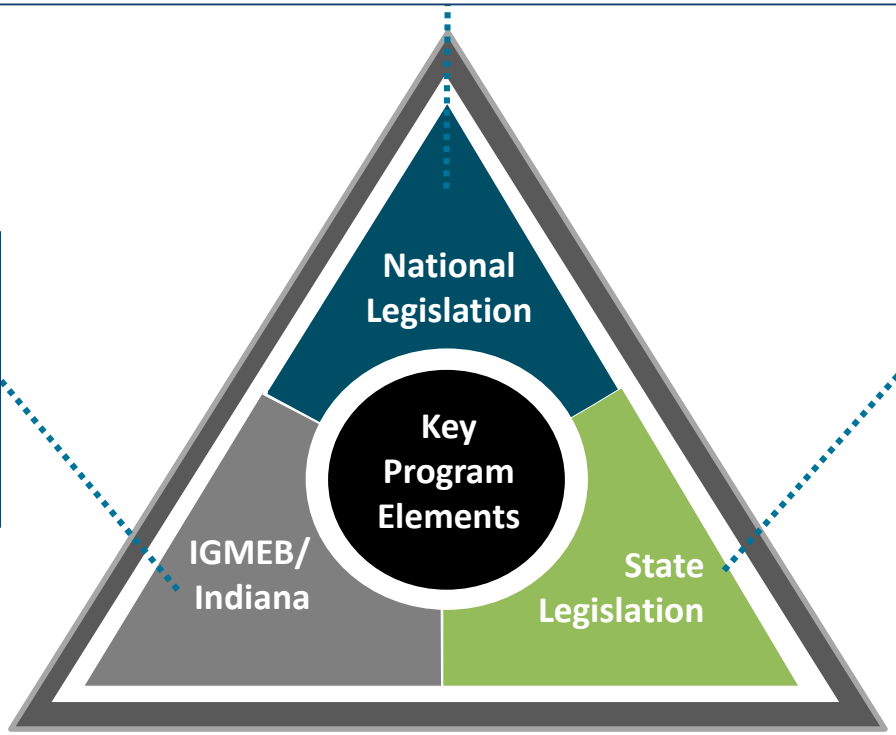
LEGISLATIVE EVALUATION

Legislative Evaluation – Overview

- Our legislative evaluation will review and monitor all legislation that could have an impact on Indiana's GME development both currently and in the near future

National – Legislation that will provide the ability to increase GME funding though federal agencies including increasing the number of funded residency positions **(H.R. 4732)** and those that would reset caps for select existing hospitals **(H.R. 4774)**

IGMEB/Indiana – Under Current GME Board activities and other targeted approaches in Indiana (e.g. Indiana Primary Care Scholarship Program (PCSP)



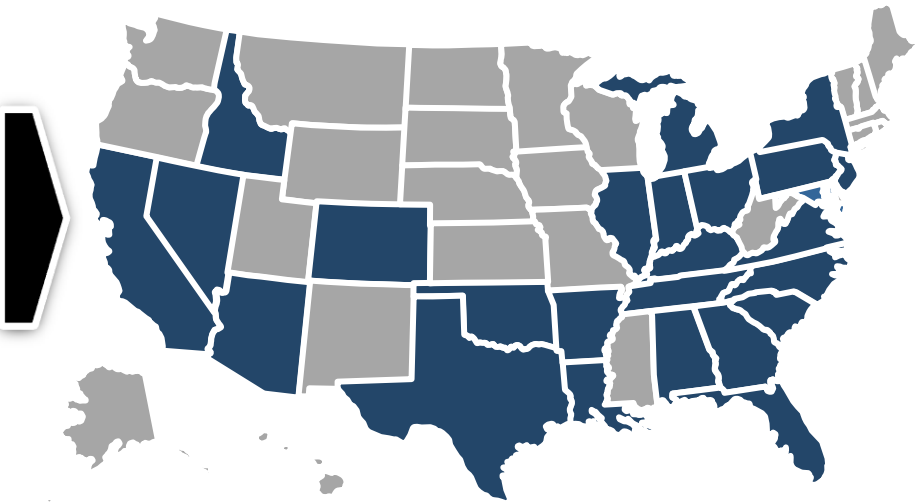
State – Gather information on design, structure, and results of other state-funded GME expansion efforts throughout the U.S.

Legislative Evaluation – Picking the Right Model

- One of the keys for the Board will be to determine if their funding model is the most appropriate given the GME needs of the state. We have reviewed a majority of the GME initiatives in other states, and can provide recommendations on how to best structure the GME funds distribution.

	Funding Type	State Examples
1	Provides appropriations available directly to hospitals and other entities to support GME programs	AZ, IL, HI, IN, LA, MI, MO, NE, OH, UT, VA, WA
2	Provides funding for GME to support entities affiliated with state based medical schools	FL, SC, MN, NC, OK, TN
3	Provides funding to offset the cost of starting GME programs	GA, MS, TX
4	Provides funding to support to institutions operating GME in underserved areas	DE, NM, OR

States where Germane is currently developing new GME Programs



Legislative Evaluation – Key Language

- Based on our initial review of the legislation, we have identified some preliminary parameters that we would likely include in developing the framework for funds distribution:
  - **All applying entities should provide a written commitment to achieve and maintain all accreditation requirements for the specific programs;**
  - **25% matching requirement should include in kind donations and "credit" provided to institutions that invest in the GME development process (such as a portion of a Program Directors salary that was spent developing applications)**
  - **Financial participation by institutions at a minimum should include enough funding to support 50% of the salary of the program director for each program being expanded or developed.**

Questions?

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