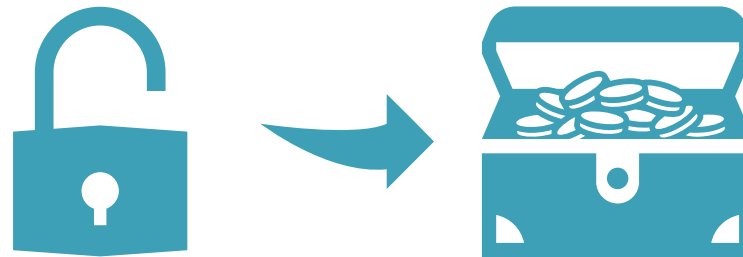


# CRACKING THE CODE

## Understanding GME Finance and the Path to Expansion

Mark Harbott, MD, MHA  
Designated Institutional Official  
Senior Associate Dean of GME  
Baylor College of Medicine



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## Financial Disclosures

- I do not have any relationships to report with ACCME defined ineligible companies.
- I will not be discussing unlabeled/investigational uses of medical devices or pharmaceuticals during this presentation.

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# Objectives

**FOLLOW THE  
MONEY TRAIL**

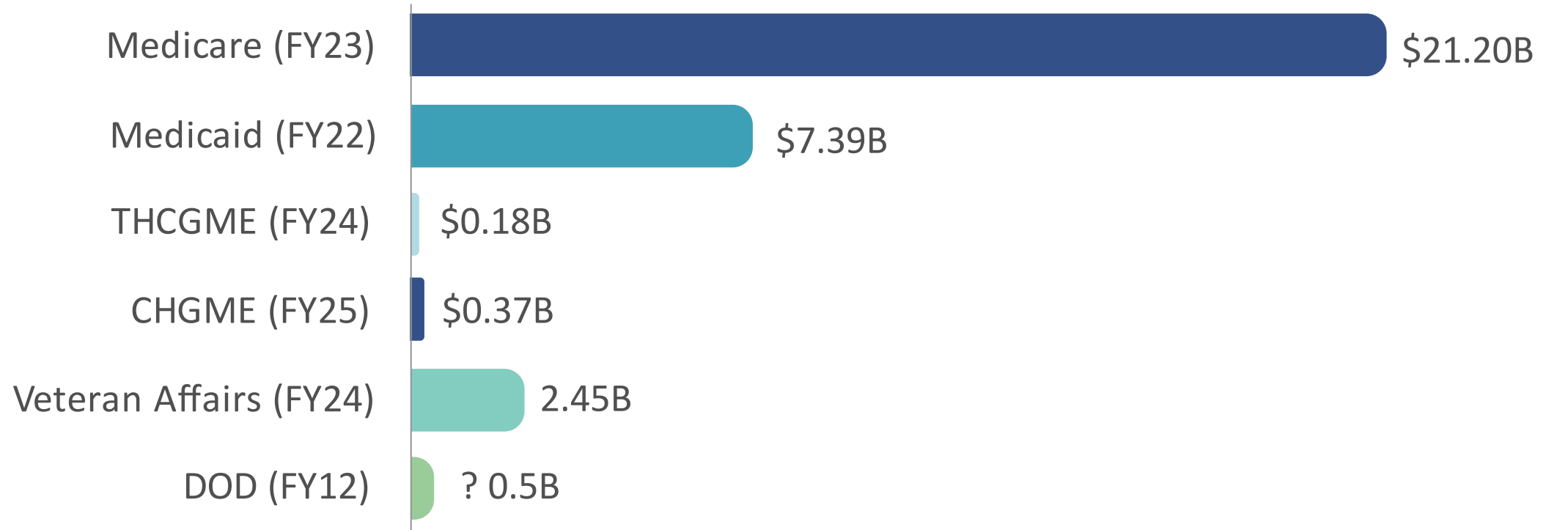
**THE 1997  
PROBLEM**

**STRATEGIES  
FOR GME  
EXPANSION**

## How GME Funding Works

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# Current Major Funding Sources



Funding in Billions

# The 1997 Problem

- In 1997, Congress passed the Balanced Budget Act
- BBA established hospital-specific caps on Medicare-funded residency positions based on each institution's **1996 resident count**
- The cap was set using a 3-year rolling average of each hospital's FTE residents as of December 31, 1996
- This initiative was based on projections of a **physician surplus** that never materialized

# Medicare Funding

- Medicare provides two types of payments to teaching hospitals:

### DGME

#### Direct Medical Education

Resident salaries and benefits  
Faculty teaching costs  
Program administration  
Overhead related to training

### IME

#### Indirect Medical Education

Offset for higher patient care costs in  
teaching hospitals

# DGME

**DGME Payment =**

Hospital Per  
Resident Amount  
(PRA)

X

Weighted FTE  
Residents  
(capped)

X

Medicare Patient  
Percentage

## DGME Average Payments

Average cost per trainee

**\$180,000–\$200,000**

Average Medicare DGME  
payment per resident

**\$51,000**

## Medicare Funding

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### IME

- An adjustment to inpatient payments
- **DGME** funds direct training costs; **IME** reflects teaching intensity via resident-to-bed ratios
- IME recognizes that teaching hospitals
  - Treat sicker patients
  - Use more diagnostic testing
  - Have longer LOS
  - Are less operationally efficient due to teaching
- **Little accountability** for how IME funds are used

## Medicare Funding

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### IME

*IME Adjustment Factor*

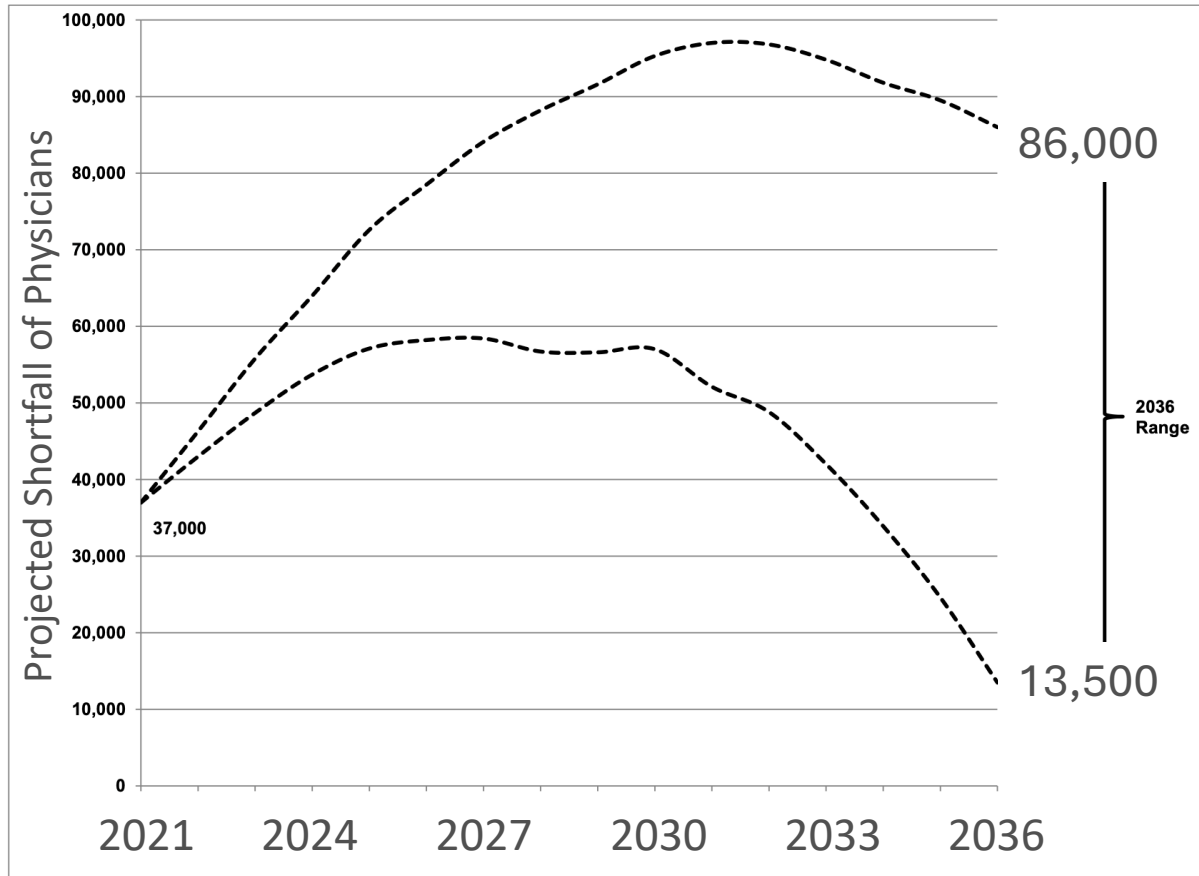
$$= c \times \left[ \left( 1 + \frac{\text{Residents}}{\text{Beds}} \right)^{0.405} - 1 \right] \times (\text{Medicare DRG Payments})$$

### Bottom Line:

- More residents per bed and more Medicare patients = more \$\$\$
- Average teaching adjustment is about 5-6% per Medicare admission

## Physician Shortage and Funding Gap

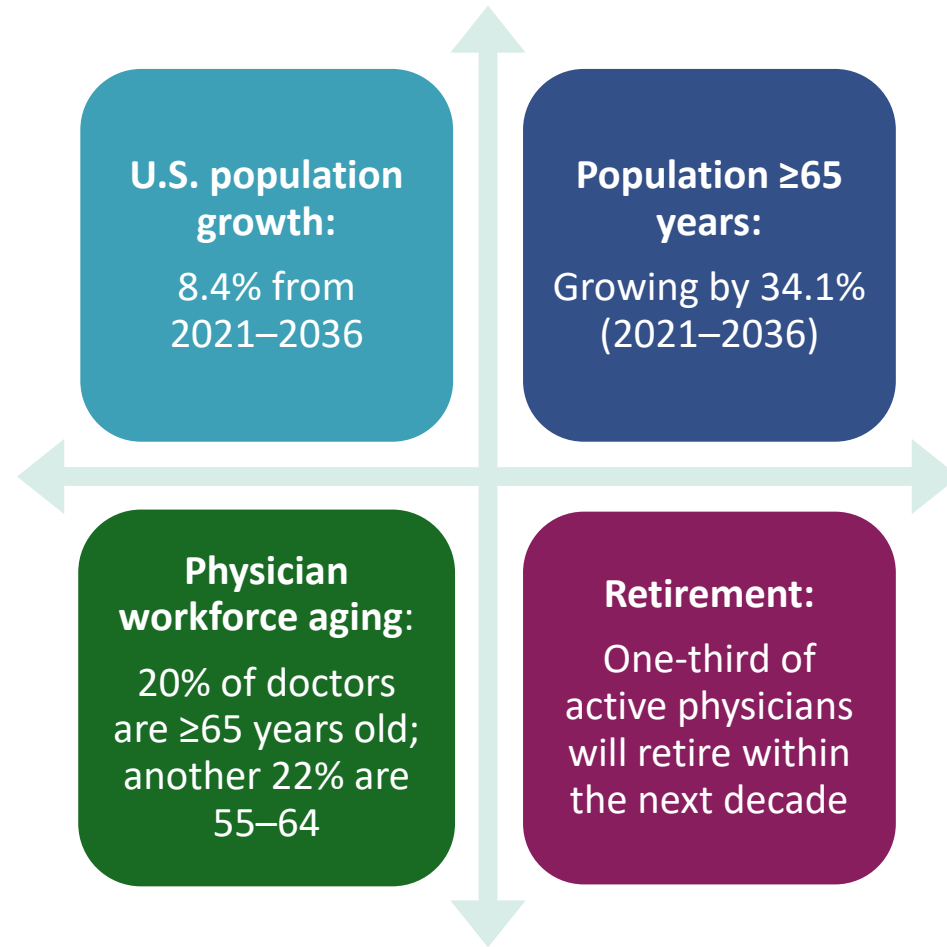
# AAMC Predicts Physician Shortage



Surgical specialties  
shortage:  
**10,100 to 19,900  
physicians**

Source: AAMC 2024

# What is driving the shortage?



Source: AAMC 2024

## What Does it Look Like for Urology?

**61.5%**

Counties have no practicing urologists

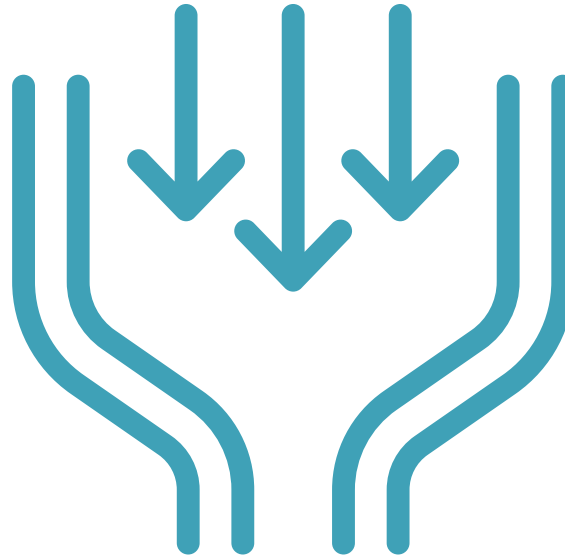
**Supply**

Projected to decrease from 11,900 to 11,600 (2025-2037)

**Demand**

Projected to increase from 12,790 to 14,190 (2025 – 2037)

## The Training Bottleneck

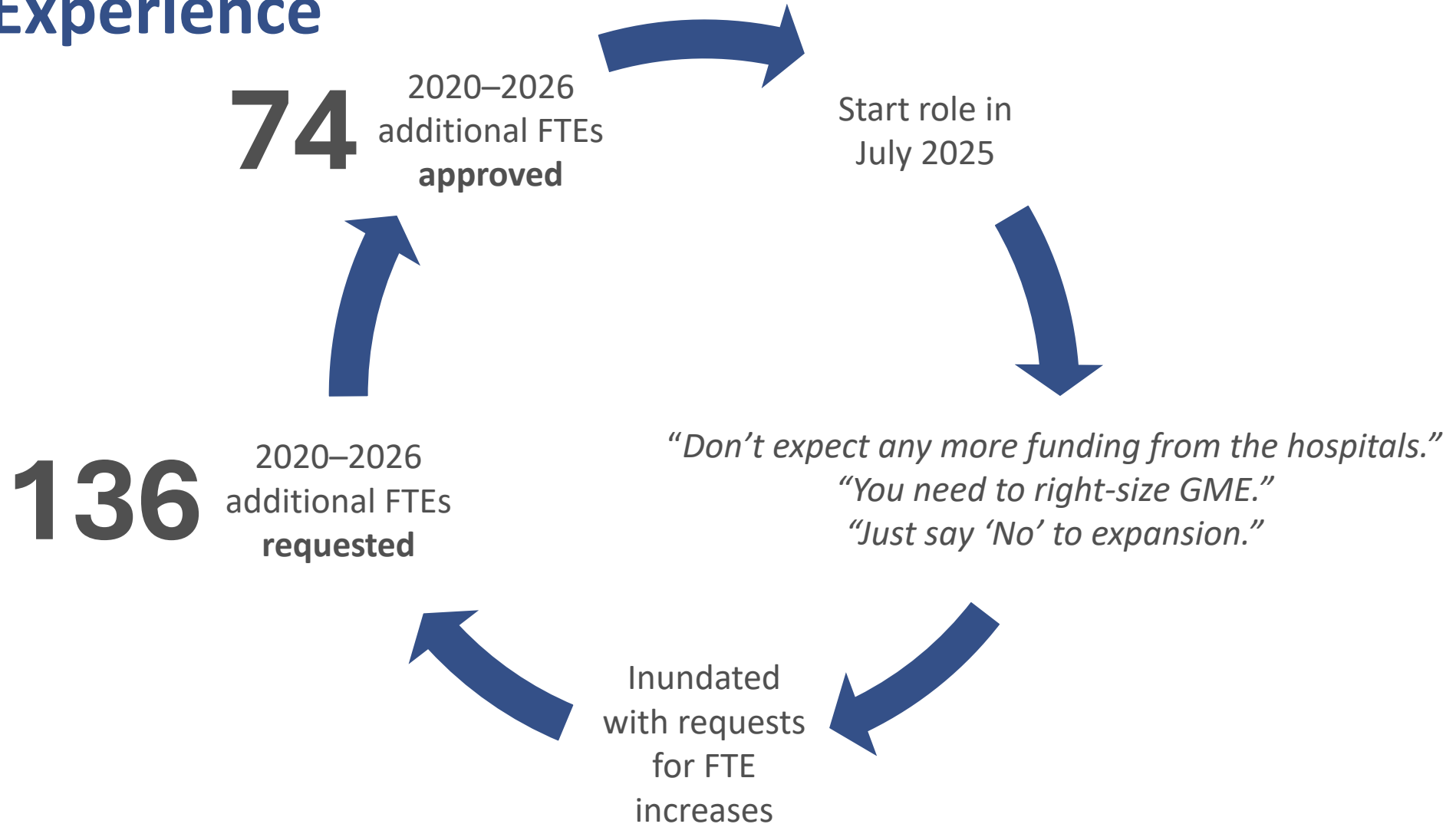


- The 2025 Urology Match had 148 registered programs and filled all 403 positions

# Strategies for Expanding Training Slots at Your Institution

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## My Experience



Strategies for Expanding Training Slots at Your Institution

# You Are a PD and You Want to Expand Your Program



# Before You Make the Request

- Be on the same page as Chair and Vice Chair of Education
- Verify adequate case volume
- Establish need for office space/call rooms
- Secure faculty commitment for increased supervision time (faculty practice revenue impact during teaching)
- Commitment to support any increase in required leadership protected time
- Consider equipment and technology costs (simulation, loops)
- **Estimate the true cost of training additional residents**

## Estimate the True Costs of Training a Resident

- AAMC estimated an average cost of **\$187,988** to train a resident in FY22.

### Direct Costs

Salary ranges:

\$66,986 for a PGY-1 (median)

\$94,215 for PGY-8 (median)

### Indirect Costs

Teaching time

Simulation

Scholarship

Equipment

### Meet With Your DIO

- Knows the appetite for expansion and the players
- Knows the budget timelines
- Knows if the hospitals are over the cap
- Knows about potential alternative funding sources
- Knows the hospitals' strategic priorities
- Advocates for educational quality while being transparent about financial constraints

# Be Aware of Alternative Funding Sources

- **New Medicare slots:**
  - **Section 126 (CAA 2021):** 1,000 new Medicare slots being distributed over 5 years, 200 per year beginning FY23.
  - **Section 4122 (CAA 2023):** Up to 200 additional FTE positions, first distribution in 2025
  - **Priority criteria** include
    - Located in rural areas (or treated as rural)
    - Training more residents than their current Medicare cap
    - States with new medical schools or branch campuses
    - Hospitals serving Health Professional Shortage Areas (geographic HPSAs)

# Be Aware of Alternative Funding Sources

### Medicaid GME

- No federal caps
- Responsive to state workforce needs
- 43 state Medicaid programs

### VA

- Not directly capped
- Defined request process
- Unpredictable
- Strict rules

### State Support

- Some states have GME support programs
- Florida
- Texas

### Other

- Philanthropy
- Alumni
- Medical device grants

# Know Your Audience

### GMEC

- Educational merits
- Sufficient educational resources
- Impacts on other learners
- Appropriate protected time for program administration

### Hospital CEO/CFO

- Cost avoidance
- Throughput
- Pipeline
- Institutional mission, strategic plan alignment

# Make the Business Case to the Hospital

- **Highlight resident value:**
  - Senior residents can help with RVU production (clinic visits, surgical assists)
  - Provision of essential services (call coverage)
  - Relatively inexpensive compared to APP (~2x salary), and usually work more than 1 FTE (emphasize cost avoidance), and substantially less expensive than faculty
- **Workforce need:**
  - Emphasize the regional specialty shortage if appropriate
  - Residents tend to stay in the states where they train

# Make the Business Case to the Hospital

- **Quality metrics:**

- The presence of residents provides additional layers of assessment and may contribute to improved care (early detection of clinical deterioration)
- Teaching hospitals often handle more complex cases and have been associated with better adherence to evidence-based protocols
- Structured resident handoff training (I-PASS) reduces preventable adverse events
- Residents improve time-to-consult, overnight response times
- **Residents are key drivers of institutional quality**, and academic medical centers rely on resident participation for successful quality-improvement programs.

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## Conclusion

- The cap is real, the funding is outdated, and the need for physicians is growing
- But expansion *is* possible when we understand the system, build the right partnerships, and make a clear case for the value our trainees bring
- We can't wait for the system to change — we have to navigate it strategically to grow the workforce our patients need

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## Slide 8: DGME Average Payments

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## Slide 11-12: AAMC Predicts Physician Shortage and What is Driving the Shortage?

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## Slide 13: What does it look like for Urology?

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## Slide 18: Appreciate the True Costs of Training a Resident

- Association of American Medical Colleges. Teaching Hospital Characteristics. March 2025. <https://www.aamc.org/media/10266/download>

## Slides 23-24 Step 5: Make the Business Case

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