Funding for Accountability, Sustainability and Transparency (FAST) in Medical Education

A Proposed Model for Meeting Physician Workforce Needs

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Twitter: @KCaverzagie
Objectives

Audience members will:

• Outline the details of a potential new model for GME funding

• Describe the potential implications of the proposed model for availability of GME slots to meet the service needs of patients and address future workforce needs

• Engage in a vigorous discussion and new thinking about the funding of UME and GME

• Learn 1-2 items that can be applied in their local context
Agenda

1. Background about UME and GME Funding
2. Institute of Medicine Report on GME Financing
3. All-payer proposal for UME and GME Funding
4. Nebraska FAST Demonstration Project
5. Facilitated discussion and debate
# Background – UME Funding

## D2. All U.S. Fully Accredited Medical School Revenue by Category, $ in Millions

<table>
<thead>
<tr>
<th>Fully Accredited Medical Schools</th>
<th>2013-14</th>
<th>2012-13</th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Schools</td>
<td>130</td>
<td>129</td>
<td>126</td>
<td>126</td>
</tr>
<tr>
<td>Number of Schools Reporting</td>
<td>130</td>
<td>129</td>
<td>126</td>
<td>126</td>
</tr>
<tr>
<td><strong>Category</strong></td>
<td><strong>Amount</strong></td>
<td><strong>Pct</strong></td>
<td><strong>Amount</strong></td>
<td><strong>Pct</strong></td>
</tr>
<tr>
<td>Federal Appropriations</td>
<td>$349</td>
<td>0.3%</td>
<td>$313</td>
<td>0.3%</td>
</tr>
<tr>
<td>State/Local Govt/Parent Univ. Support</td>
<td>5,365</td>
<td>5.1%</td>
<td>5,138</td>
<td>5.1%</td>
</tr>
<tr>
<td>Practice Plans</td>
<td>12,200</td>
<td>10.3%</td>
<td>39,309</td>
<td>39.1%</td>
</tr>
<tr>
<td>Tuition and Fees</td>
<td>4,007</td>
<td>3.8%</td>
<td>3,786</td>
<td>3.8%</td>
</tr>
<tr>
<td>Endowment</td>
<td>2,655</td>
<td>2.0%</td>
<td>2,097</td>
<td>2.1%</td>
</tr>
<tr>
<td>Gifts</td>
<td>2,433</td>
<td>2.3%</td>
<td>2,547</td>
<td>2.5%</td>
</tr>
<tr>
<td>Hospitals/Medical School Programs</td>
<td>18,643</td>
<td>17.8%</td>
<td>17,255</td>
<td>17.2%</td>
</tr>
<tr>
<td>Miscellaneous Sources</td>
<td>4,290</td>
<td>4.1%</td>
<td>3,976</td>
<td>4.0%</td>
</tr>
<tr>
<td>Grants and Contracts</td>
<td>25,571</td>
<td>24.4%</td>
<td>26,219</td>
<td>26.0%</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td><strong>$105,012</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>$100,650</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Note: All years represent fiscal years. Numbers and percents may not add to totals due to rounding.
Source: LCME Part I-A Annual Financial Questionnaire, Updated 10/2015
Contact: AAMC Data Request, datarequest@aamc.org
Background – GME Funding

- **Medicare Legislation (1965)** – the costs of GME funding should “be borne to an appropriate extent by the hospital insurance program”

- **Indirect Medical Education (IME)** – intended to reimburse teaching hospitals for the increased costs of patient care related to teaching programs

- **Direct Graduate Medical Education (DGME)** – intended to cover the costs directly related to running GME programs
Background – GME Funding

FIGURE: Estimated sources of $15 billion in public funding for GME

NOTE: Additional unreported funding comes from the Department of Defense, state sources, private insurers, and other private sources. \(^a\) = data from 2012; \(^b\) = data from 2011 and 2013.
Background – Threats to GME Funding

Chapter 4

Graduate medical education financing: Focusing on educational priorities

MedPAC
2010

US Congress
2014

OPEN LETTER REQUESTING INFORMATION ON GRADUATE MEDICAL EDUCATION

Federal contributions — primarily under Medicare financing — have been the principal source of funds for graduate medical education (GME) in this country, and no other profession enjoys a comparable level and type of government support. However, concerns about the sustainability and efficiency of the GME program persist. Earlier this year, the Institute of Medicine (IOM) released a report examining and making recommendations for sweeping changes to our nation’s financing, governance, and program design for graduate medical education. As Congress prepares to review the IOM recommendations, we believe additional input is needed.

Given the importance of graduate medical education, we would like your thoughts on GME financing, federal program governance and structure, and how it might be improved or restructured to better meet the country’s health professional needs in both the short and long terms. Specific questions for which we seek input include:

FRED UPTON, MICHIGAN
CHIEFHAND

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Cgress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 Rayburn House Office Building
Washington, DC 20515-6115
Majority: (202) 225-3277
Minority: (202) 225-3281
December 6, 2014
What are the outcomes?

Gaps in individual readiness for “unsupervised faculty”
Crosson et al. Health Affairs, 2011

Deficiency in core surgical skills

Inadequate access to medical services
HRSA, National Center Workforce Analysis

Committee on Governance and Financing of GME
Institute of Medicine, July 2014
Physician Supply and Demand (2025)

- Demand for physicians growing faster than supply
- Total physician demand projected to grow by 17% (shortage between 46,000 to 90,000 physicians)
  - Primary Care = 12-31K shortage
  - Medical Specialty = 5-12K shortage
  - Surgical Specialty = 23-31K shortage
  - Other = 2-20K shortage
“There is a striking absence of transparency and accountability in the GME financing system for producing the types of physicians that the nation needs.”

**Recommendation:**
Replace Medicare GME payment system with a two-part system:
- Operations fund
- Transformation fund
Envisioning a Future Governance and Funding System for Undergraduate and Graduate Medical Education

Jeffrey P. Gold, MD, Jim P. Stimpson, PhD, and Kelly J. Caverzagie, MD

Abstract

Funding for graduate medical education (GME) and undergraduate medical education (UME) in the United States is being debated and challenged at the national and state levels as policy makers and educators question whether the multibillion dollar investment in medical education is succeeding in meeting the nation’s health care needs. To address these concerns, the authors propose a novel all-payer system for GME and UME funding that equitably distributes medical education costs among all stakeholders, including those who benefit most from medical education. Through a “Medical Education Workforce (MEW) trust fund,” indirect and direct GME dollars would be replaced with a funds-flow mechanism using fees paid for services by all payers (Medicaid, Medicare, private insurers, others) while providing direct compensation to physicians and institutions that actively engage medical learners in providing clinical care. The accountability of those receiving MEW funds would be improved by linking their funding levels to their ability to meet predetermined institutional, program, faculty, and learner benchmarks. Additionally, the MEW fund would cover learners’ UME tuition, potentially eliminating their UME debt, in return for their provision of health care services (after completing GME training) in an underserved area or specialty. This proposed model attempts to increase transparency and enhance accountability in medical education by linking funding to the development of a physician workforce that is able to excel in the evolving health delivery system. Achieving this vision requires physician educators, leaders of academic health centers, policy makers, insurers, and patients to muster the courage to embrace transformational change.
Our Goals

• Provocative and start a conversation amongst key stakeholders
• Move beyond structured thinking that is guided by policy and process
• Stimulate research and innovation
• Inspire change
Holdredge, Nebraska
Population: 5,600
Our Proposal

• Novel all-payer system for GME and UME funding

• Accountable: Physician workforce that meets the needs of patients and populations

• Transparent: Funding for GME and UME is trackable, flexible and predictable

• Budget Neutral: Overall % of national health expenditure remains static

• Talk to a neighbor …
  - What would it take to accomplish this?
Disclaimer

I have no conflicts of interest to report

What I am…
- Clinician Educator
- Provocateur
- Patient / Family
- Citizen of Nebraska

What I am NOT…
- Workforce Expert
- Health Policy Expert
- Health Economist
- Crazy (?)
National Health Expenditure by Payer Source

Table 1
2012 and 2013 U.S. National Health Expenditure (NHE) by Payer Source

<table>
<thead>
<tr>
<th>Payer source</th>
<th>2012 expenditure, total ($)</th>
<th>2013 expenditure, total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$567B (20.1)</td>
<td>$586B (20.1)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$424B (15.1)</td>
<td>$449B (15.4)</td>
</tr>
<tr>
<td>Private insurance</td>
<td>$936B (33.2)</td>
<td>$962B (33.0)</td>
</tr>
<tr>
<td>Patients</td>
<td>$329B (11.7)</td>
<td>$339B (11.6)</td>
</tr>
<tr>
<td>Other(^a)</td>
<td>$563B (20.0)</td>
<td>$583B (20.0)</td>
</tr>
<tr>
<td><strong>Total NHE</strong></td>
<td><strong>$2,817B</strong></td>
<td><strong>$2,919B</strong></td>
</tr>
</tbody>
</table>

Abbreviation: B indicates billion.
\(^a\)Includes health-related spending for Children’s Health Insurance Program (CHIP), Titles XIX and XXI, U.S. Department of Defense, U.S. Department of Veterans Affairs, other third-party payers and programs, public health activities, and investments.

Hartman, *Health Affairs*, 2015
Predicted MEW Revenue and Expenditures (2013)

Educational assessment (EA) – surcharge on service and fees
Educational incentive (EI) – encourage supervision and learning environment
Tuition-for-service fee (TFS) – offset costs of tuition
Impact on GME – MEW Fund Revenue

Educational Assessment (EA) - surcharge applied to:

• Professional and facility fees for govt. and non-govt. health care payers (e.g. Medicare, Medicaid, private insurers, etc.)

• Fees for services provided by physicians, hospitals, ambulatory centers and nursing facilities

• Charges to payers of other health related services (e.g. prescription meds, devices, DME)

• 0.6% - approximates total NHE of GME (2012)
## Impact of EA - GME funding by Payer Source

<table>
<thead>
<tr>
<th>Payer source</th>
<th>Total(^a)</th>
<th>% NHE(^b)</th>
<th>% GME(^c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$9.7B</td>
<td>0.34</td>
<td>62.6</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$3.9B</td>
<td>0.14</td>
<td>25.2</td>
</tr>
<tr>
<td>Private insurance</td>
<td>$0.0B</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patients</td>
<td>$0.0B</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other(^g)</td>
<td>$1.9B</td>
<td>0.07</td>
<td>12.3</td>
</tr>
<tr>
<td><strong>Total GME expenditures</strong></td>
<td><strong>$15.5B</strong></td>
<td><strong>0.55</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

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**FIGURE:** Estimated sources of $15 billion in public funding for GME

*NOTE: Additional unreported funding comes from the Department of Defense, state sources, private insurers, and other private sources.*

\(^a\) Estimated.
\(^b\) Percent of total NHE for that payer source. For example, the 2013 Medicare GME expenditure.
\(^c\) Percent of total GME expenditure. For example, the 2013 Medicare GME expenditure.
\(^g\) Includes all payer sources.
### Table 2: Graduate Medical Education (GME) Expenditures by Payer Source Before (2012) and After (MEW) Medicare and Medicaid Expenditures

<table>
<thead>
<tr>
<th>Payer source</th>
<th>Total(^d)</th>
<th>% NHE(^e)</th>
<th>% GME(^f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$3.5B</td>
<td>0.12</td>
<td>20.0</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$2.7B</td>
<td>0.09</td>
<td>15.4</td>
</tr>
<tr>
<td>Private insurance</td>
<td>$5.8B</td>
<td>0.20</td>
<td>33.0</td>
</tr>
<tr>
<td>Patients</td>
<td>$2.0B</td>
<td>0.07</td>
<td>11.4</td>
</tr>
<tr>
<td>Other(^g)</td>
<td>$3.5B</td>
<td>0.12</td>
<td>20.0</td>
</tr>
</tbody>
</table>

**Total GME expenditures:** $17.5B

\(^d\)Total 2012 Medicare GME contribution of $2.7B was 0.6% of the 2012 total GME expenditures. Together, Medicare, Medicaid, and other governmental sources account for 100% of total GME expenditures. Percentages may not total 100 because of rounding.

\(^e\)Total 2013 GME contributions by payer source if a 0.6% EA had been applied to 2013 total NHE for that payer source. For example, $3.5B is 0.6% of the 2013 total Medicare NHE ($586B; see Table 1).

\(^f\)Percent contribution of each payer source as a function of the 2013 total NHE. For example, the 2013 Medicare GME contribution of $3.5B would be 0.12% of the 2013 total NHE ($2,919B; see Table 1). The total GME expenditure by all payer sources equals 0.6% of 2013 total NHE.

\(^g\)Percent contribution of each payer source as a function of the 2013 total GME expenditure. For example, the 2013 Medicare GME contribution of $3.5B would be 20.0% of the 2013 total GME expenditures. Together, Medicare, Medicaid, and other governmental sources account for only 55.4% of total GME expenditures. Percentages may not total 100 because of rounding.

\(^\text{includes GME spending for Veterans Administration and the Health Resources and Services Administration.}\)
## Comparison of GME Expenditures by Payer

<table>
<thead>
<tr>
<th>Payer Source</th>
<th>GME Expenditure 2012 (Pre)</th>
<th>GME Expenditure 2013 (Post)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$9.7B</td>
<td>$3.5B</td>
<td>-$6.2B</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$3.9B</td>
<td>$2.7B</td>
<td>-$1.2B</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>$0.0B</td>
<td>$5.8B</td>
<td>$5.8B</td>
</tr>
<tr>
<td>Patients</td>
<td>$0.0B</td>
<td>$2.0B</td>
<td>$2.0B</td>
</tr>
<tr>
<td>Other</td>
<td>$1.9B</td>
<td>$3.5B</td>
<td>$1.6B</td>
</tr>
<tr>
<td><strong>Total GME Expenditures</strong></td>
<td><strong>$15.5B</strong></td>
<td><strong>$17.5B</strong></td>
<td><strong>+$2.0B</strong></td>
</tr>
</tbody>
</table>
Predicted MEW Revenue and Expenditures (2013)

Educational assessment (EA) – surcharge on service and fees
Educational incentive (EI) – encourage supervision and learning environment
Tuition-for-service fee (TFS) – offset costs of tuition
Impact on GME – MEW Fund Expenditures

DME and IME Funding – sustained as prior ($15.5B)

Educational Incentive (EI) – ($2.9B)

- Physicians and clinics actively contributing to the clinical education of a medical student, resident or fellow (estimated 5% of encounters)

- Additional 10% payment per clinical encounter (5% of $587B* = $29B) ($29B x 10% = $2.9B)

- Purpose: Incentivize active supervision of learners and maintenance of effective learning environment

* - Total NHE of physician and clinical service
Hartman, Health Affairs, 2015
Predicted MEW Revenue and Expenditures (2013)

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational assessment (EA)</td>
<td>$17.5B</td>
<td>Sustained DME and IME funding to hospitals and clinics</td>
<td>$15.5B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Educational incentive (EI)</td>
<td>$2.98</td>
</tr>
<tr>
<td>Tuition-for-service (TFS) fee</td>
<td>$2.88</td>
<td>All sources</td>
<td>$21.88</td>
</tr>
<tr>
<td>Tuition repayment</td>
<td>$1.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuition and fees</td>
<td>$3.4B</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: GME indicates graduate medical education; B, billion; DME, direct medical education; IME, indirect medical education; UME, undergraduate medical education.
*This illustration does not account for annual cost-of-living increase.
*Based on 0.6% fee to all health care payers (see Tables 1 and 2).
*Estimating that 75% of all medical students (n = 69,225) participate in the TFS program with a TFS fee of $40,000 per physician per year.
*Estimating that 25% of all medical students (n = 23,075) do not participate in the TFS program and are required to pay back their UME tuition at an average of $82,000 per year.
*Estimating 72,312 medical students enrolled in MD-granting medical schools with a median, in-state cost of tuition and fees of $34,540, and 19,988 medical students enrolled in osteopathic medical schools with a median, in-state cost of tuition and fees of $43,982.
Notably, revenues exceed expenditures, allowing a margin of 0.48.

Educational assessment (EA) – surcharge on service and fees
Educational incentive (EI) – encourage supervision and learning environment
Tuition-for-service fee (TFS) – offset costs of tuition
Background – UME Funding

- Limits student access to medical education
- Increased attrition, especially for underrepresented minorities
- Influences specialty choice and location of practice
- Impact = direct effect on public health

### Medical Student Education: Debt, Costs, and Loan Repayment Fact Card

<table>
<thead>
<tr>
<th>Indebted Graduates Class of 2014*</th>
<th>Public</th>
<th>Private</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pct. with Ed. Debt</td>
<td>86%</td>
<td>82%</td>
<td>84%</td>
</tr>
<tr>
<td>Mean</td>
<td>$167,763 (↑3%)</td>
<td>$190,053 (↑5%)</td>
<td>$176,348 (↑4%)</td>
</tr>
<tr>
<td>Median</td>
<td>$170,000 (↑1%)</td>
<td>$200,000 (↑5%)</td>
<td>$180,000 (↑3%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education Debt (including premed) of:</th>
<th>Public</th>
<th>Private</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100,000 or more</td>
<td>80%</td>
<td>79%</td>
<td>79%</td>
</tr>
<tr>
<td>$200,000 or more</td>
<td>37%</td>
<td>51%</td>
<td>43%</td>
</tr>
<tr>
<td>$300,000 or more</td>
<td>6%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Planning to enter loan forgiveness/repayment program:</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Debt</th>
<th>% Graduates</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premedical Education Debt</td>
<td>34%</td>
<td>$20,000</td>
</tr>
<tr>
<td>Non-education Debt</td>
<td>22%</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

*Source: FIRST analysis of AAMC 2014 GQ data. Education debt figures include premedical education debt. Non-education debt includes car, credit card, residency relocation loans, etc.

### Cost, M1 In-State, 2014-15

<table>
<thead>
<tr>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Tuition &amp; Fees</td>
<td>$34,540 (↑4%)</td>
</tr>
<tr>
<td>Median Cost of Attendance (COA)</td>
<td>$56,779 (↑12%)</td>
</tr>
<tr>
<td>Median 4-Yr. COA for Class of 2015</td>
<td>$226,447 (↑3%)</td>
</tr>
</tbody>
</table>

Source: AAMC-TPS survey preliminary data from 83 public schools and 93 private schools.

Verduin, *Acad Psychiatry*, 2014
Brewer, *AAMC*, 2011
AAMC GQ, 2013, 2014
Impact on UME – MEW Fund Expenditures

Tuition and Fees – ($3.4B)

• MEW to finance entire cost of tuition and fees for all medical students per year

• Allopathic schools ($2.5B)
  
  (72,312 students x $34,540 median, in-state tuition & fees)

• Osteopathic schools ($0.9B)
  
  (19,988 students x $43,982 median, in-state tuition & fees)
Predicted MEW Revenue and Expenditures (2013)

<table>
<thead>
<tr>
<th>Source</th>
<th>MEW Revenue</th>
<th>Source</th>
<th>MEW Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>GME</td>
<td>$17.5B</td>
<td>• Sustained DME and IME funding to hospitals</td>
<td>$15.5B</td>
</tr>
<tr>
<td>Educational assessment (EA)</td>
<td>$17.5B</td>
<td>and clinics</td>
<td>$2.9B</td>
</tr>
<tr>
<td>Educational incentive (EI)</td>
<td>$2.8B</td>
<td>Educational incentive (EI)</td>
<td>$2.9B</td>
</tr>
<tr>
<td>Tuition-for-service (TFS) fee</td>
<td>$2.8B</td>
<td>Tuition and fees</td>
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</tr>
</tbody>
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**Abbreviations:**
- GME indicates graduate medical education; B, billion; DME, direct medical education; IME, indirect medical education; UME, undergraduate medical education.
- *This illustration does not account for annual cost-of-living increases.*
- *Based on 0.6% fee to all health care payers (see Tables 1 and 2).*
- *Assuming that 75% of all medical students (n = 69,225) participate in the TFS program with a TFS fee of $40,000 per physician per year.*
- *Assuming that 25% of all medical students (n = 23,075) do not participate in the TFS program and are required to pay back their UME tuition at an average of $62,000 per year.*
- *Estimating 72,312 medical students enrolled in MD-granting medical schools with a median, in-state cost of tuition and fees of $34,540, and 19,988 medical students enrolled in osteopathic medical schools with a median, in-state cost of tuition and fees of $43,982.*
- *Notably, revenues exceed expenditures, allowing a margin of $0.48.*
Tuition-for-Service (TFS) Program

- Physicians provide service to designated communities or populations (year for year)
- Service areas determined by specialty and geographic workforce needs
- Participating physicians paid baseline advanced-resident level salary directly from MEW Fund (still eligible for supplemental income from services provided)
- Participating clinic/hospital reimburse MEW Fund salary plus a TFS Fee of $40K per year
  - $40K approximates yearly tuition & fees
Impact on UME – MEW Fund Revenue

Tuition-for-Service Fee – ($2.8B)

• If 75% of eligible physicians (n=69,225) complete service obligation x $40K = $2.8B

• Benefit to clinic/hospital
  - Adv. resident salary + TFS Fee < recruitment costs
  - Opportunity for long-term retention

• Note: Military service, VA service, NHSC, scholarships “count” as service time
Impact on UME – MEW Fund Revenue

Tuition repayment – ($1.9B)

- Physicians not fulfilling service obligation will repay full costs of tuition

- Estimated total repayment of $328K if student claims forbearance and repay over 10 years (average yearly repayment of $82K per year)

- If 25% of eligible physicians (n=23,075) do not complete service obligation x $82K = $1.9B

AAMC Fact Card, 2014
Predicted MEW Revenue and Expenditures (2013)

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>GME</td>
<td></td>
<td>Sustained DME and IME funding to hospitals and clinics</td>
<td>$15.5B</td>
</tr>
<tr>
<td>* Educational assessment (EA)*</td>
<td>$17.5B</td>
<td>Educational incentive (EI)</td>
<td>$2.9B</td>
</tr>
<tr>
<td>UME</td>
<td></td>
<td>* Tuition-for-service (TFS) fee</td>
<td>$2.8B</td>
</tr>
<tr>
<td>* Tuition repayment</td>
<td>$1.98</td>
<td>* Tuition and fees</td>
<td>$3.48</td>
</tr>
</tbody>
</table>

| GME and UME combined¹ | All sources | $22.2B | All sources | $21.8B |

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**Educational assessment (EA)** – surcharge on service and fees
**Educational incentive (EI)** – encourage supervision and learning environment
**Tuition-for-service fee (TFS)** – offset costs of tuition
MEW Fund Surplus ($0.4B)

- Reinvest in GME and UME
- Growth in GME training based upon regional workforce needs
4 yr. service in Nebraska
Debt-Free Medical Education
Specialty of Choice

Resident salary + $40K annually
Physician in needed specialty

0.6% surcharge on services
Better access to care

0.6% surcharge on services
Workforce necessary to achieve goals and outcomes
Large Group Discussion

• What are the barriers to implementation?
  - Are these barriers rooted in current structures and processes?
  - Can we envision a system that does not have those barriers?

• What are the opportunities that exist given our current reality?

• How can we think differently to stabilize/improve medical education funding?
What would it take to accomplish this?

- Integration of federal, state and private resources
- Legislative and executive approval
- MEW Advisory Commission that has independent governance authority
- Policies and procedures of medical education regulatory bodies and academic institutions
- Consistent and reliable workforce projections
Nebraska FAST Demonstration Project

- Elected officials
- Nebraska DHHS
- Federal agencies
- Private insurers

- Univ of Nebraska
- Creighton University
- VA Medical Center
- Med Ed organizations
Maryland Innovations in GME

1974 – All-payer system

- GME costs are “baked in” to hospital reimbursement rates
- Adjustment annually
- Full rate reviews not always done

2016 – Modified all-payer rate setting model

- Shifting hospital revenue to global payment
- Focus on population health
- Optimize workforce distribution
Utah Medical Education Council
Medicare GME Demonstration Project

• Medicare GME funding flow directly to Utah Medical Education Council (UMEC)
• UMEC directed funds to institutions based upon identified workforce needs

Outcomes

• Targeted, responsive, accountable system
• Identify funding for resident expansion
• Growth # residents (29%) and fellows (88%)
• Increased retention rate
Nebraska FAST

Ongoing efforts:

• Greater understanding of workforce needs and drivers for the State of Nebraska

• Build relationships with partners:
  - Public policy and workforce
  - Political leadership
  - Health care payers

• Business plan to seek funding

• GME performance metrics
Nebraska FAST - Questions

• Do we focus on meeting the needs of the population/community? Hospital/health system?

• Why do physicians (our physicians) leave a community?

• What are the current efforts to impact physician workforce issues?
  - Prospective – college programs aimed at recruitment
  - Retrospective – pay off debt in return for service

• What is (will be) the interest of students/residents?

• What is (will be) the interest in the “area of need”? 
Nebraska FAST – Data Sources

• UNMC Health Professions Tracking Service
• Behavioral Health Education Center of Nebraska (BHECN)
• State of Nebraska DHHS
• AMA, AOA, AHA, AAMC, etc…
• Survey of health systems
• Survey of current / prospective students
• Others
Nebraska FAST - Barriers

• Unstable health delivery system
• Unstable national political environment
• State economy under stress
• Other competing priorities
Research Opportunities

- Consistent and reliable workforce projections
- Willingness of students and residents to fulfill service obligations
- Impact on subspecialties and unique training programs (e.g. MD/PhD programs)
- Potential benefits to non-governmental payers of health care (e.g. insurance companies)
- Others?
Summary

- Novel all-payer system for GME and UME funding
- Accountable: Physician workforce that meets the needs of patients and populations
- Transparent: Funding for GME and UME is trackable, flexible and predictable
- Budget Neutral: Overall % of national health expenditure remains static
Thank you for this opportunity!

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