Nevada Hospital Association
Nevada Hospital GME Needs
May 30, 2014

Challenges to growing GME in Nevada hospitals:

1. Most of the hospitals with the breadth and volume of clinical experience needed for both training and funding purposes are capped from a CMS funding perspective. See Exhibit 1 for potential candidates for new GME programs
2. Currently, the State of Nevada doesn't provide any funding to private hospitals to support its" proportionate share of GME costs.
    a. In addition, Nevada hospitals already subsidize on average 48% of the cost of care they provide to Medicaid recipients and those recipients are have grown by more than 50% in the last year due to health care reform.
    b. Asking hospitals to take on the financial responsibility for expanding GME is not viable in most cases.
3. The vision, time and readiness to grow GME (hospitals, medical schools, and community physicians) is a significant effort and must be not be taken lightly due the CMS funding caps.
4. To maximize funding and minimize wasted time, any process to grow GME should work to ensure program approval in the spring in time for the fall resident interview and following matching process and would need to make funding available accordingly.

Resources Needed:

One time resources: Given there are many needs and options to grow GME programs in Nevada, we have included examples for both start up and operational support (See Exhibits 2 - 4 attached) for a 60 resident program that includes psychiatric, family medicine, and internal medicine residents. The operational example is based on experience of multiple hospitals currently involved in GME across the state.

New Residency Program/New GME Hospitals: While this method of expansion takes the longest to accomplish, once hospitals with adequate volume, clinical experience and payer mix are identified, it is potentially the most likely to be viable over time. The resources needed in this circumstance will be used for start up costs prior to any resident training. Although the on-going operational costs related to a new residency program are significant ($ 20,871,000 for this 4 year program– see Exhibit 3 attached), once residents begin training, new programs can begin receiving GME payments.

See Exhibit 2 - **Start up costs** prior to resident training approximate **$1,400,000 to $2,200,000** depending on the time it takes to implement.

New Residency Program/Existing GME Hospitals – This option takes advantage of the existing infrastructure of an existing GME program (unless the number of residents is increased significantly). Since these facilities are capped from a CMS funding perspective, the one-time costs is primarily the high cost of funding direct medical education including salaries, benefits, malpractice cost of residents and the incremental faculty and support staff associated with training more residents until such time as redistributed CMS funded slots can be obtained. In addition, there will likely be some portion of start-up costs but it would likely be limited to Program Director time needed to submit the initial application but would vary depending on the specialty of the new program.

Start up costs: $130,000 - $180,000 (see Exhibit 2)
Operational costs: $6,708,000 See Exhibit 3 – with the example of a new 18 resident Internal Medicine program four years of cost the following is an estimate of the one-time resources:

Expanding Residency Program/Existing GME Hospitals – This option is probably the most flexible and quickest to accomplish but also has the high cost of funding direct medical education including salaries, benefits, malpractice cost of residents and the incremental faculty and support staff associated with training more residents until such time as redistributed CMS funded slots can be obtained.

See Exhibit 4 attached – using the example of expanding 18 residents in an Internal Medicine program the following is an estimate of the one-time resources:

Operational costs: $6,375,000

Note: While 4 years of operating funds have been included in both examples of expanding residencies in existing GME hospitals since we believe this minimum commitment is need to be made by all parties to meet the commitment to the residents matching to the program, the program may receive redistributed CMS funded slots earlier and not need all the funds initially requested. On the other hand, if CMS funded slots are not obtained, there is a risk that the expanded residency slots will be eliminated over time.

On going resources:
As noted above, Medicaid does not reimburse hospitals it's proportionate share of GME expenses. Going forward, we recommend, that Medicaid consider funding similarly to the method Medicare uses to reimburse for hospitals for GME.

How soon can Nevada hospitals be training more residents?

	Allopathic	**Osteopathic**
New Residency Programs/New GME Hospitals	3 years	1.5 years
New Residency Program/Existing GME Hospitals	2-3 years	1 year
Expanding Residency Program/Existing GME Hospitals	6-12 months	6-9 months

Summary:

We recommend that the taskforce consider a blended approach to growing GME in Nevada. Using resources to both to establish new GME programs and expand existing programs addresses the short term need of getting residents into training quickly in existing programs as well as ensuring resources are invested new programs for the longer term development of GME. We also recommend that state reestablish an on-going Medicaid reimbursement program to fund its proportionate share of GME costs.