VA Funding of Graduate Medical Education (GME)

WWAMI GME Summit, March 23, 2012
Office of Academic Affiliations, VHACO
Barbara K. Chang, MD, MA

VA Milestones

- Veterans Administration established as an independent federal agency on July 21, 1930.
- Policy Memorandum No. 2 allowed VA to establish affiliations with medical schools – Jan. 30, 1946
- Department of Veterans Affairs became cabinet level on March 15, 1989.
- Veteran’s Health Care Eligibility Reform Act of 1996 (PL 104-262)

Department of Veterans Affairs (VA)

- Second largest of 15 Cabinet Agencies
- Consists of 3 Administrations:
  - Veterans Benefits Administration (VBA)
    - Disability, pensions, vocational rehab, home loans, survivor benefits, employment services
  - National Cemetery Administration (NCA)
    - Operates and maintains 120 national cemeteries for all honorably discharged veterans, provides headstones for Veterans interred in private cemeteries
  - Veterans Health Administration (VHA)
    - Health Care, Health Professions Training, Research, Emergency Backup to DoD & part of Nat’l Disaster Medical System (HHS, DoD, VA, FEMA)

VHA Healthcare

- VA provides full range of healthcare services from primary care to complex tertiary care, including organ transplantation
- Focus on wellness: Patient-Aligned Care Teams
- Mental Health, in many sites integrated into Primary Care
- Community Living Centers (Nursing Homes)
- Hospice and Palliative Care

Veterans Health Administration (VHA)

- Largest integrated healthcare system in US (FY 10 data):
  - 152 VA Hospitals – 124 have GME
    - 607 Community-based Outpatient Clinics (CBOCs), associated with VA medical ctrs
    - Plus 6 Independent Outpatient Clinics (IOC)
  - 8.3M enrollees – 8% female
  - 5.7M patients treated annually
  - ~250K FTE employees (~65K health care, including ~17K physicians – 60% of whom trained in VA)

VHA Special Programs

- Polytrauma Centers & other partnerships with DOD
- Spinal Cord Injury Centers
- Homeless Initiative
- Women’s Health
- Centers of Excellence
  - Parkinson’s Disease
  - Geriatrics
  - Epilepsy
- Research, Quality & Patient Safety
**Scope of Training in VA**

- ~37,000 medical residents train in VA annually
  - 30% US total medical residents
- 10,300 physician resident positions (AY 2012)
  - 9% US positions funded by VA
- >2,300 ACGME-accredited programs
  - 75 medical specialties & subspecialties; 7 combined programs

<table>
<thead>
<tr>
<th>Health Profession Trainees</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Residents</td>
<td>37,104</td>
</tr>
<tr>
<td>Medical Students</td>
<td>21,507</td>
</tr>
<tr>
<td>Nursing</td>
<td>32,349</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>1,570</td>
</tr>
<tr>
<td>All other</td>
<td>24,268</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116,754</strong></td>
</tr>
</tbody>
</table>

**How does VA fund GME positions?**

- Annual resident allocation cycle in partnership with affiliates (99%)
  - Base (permanent) positions applied for in October & approved by early December in time for Match (NRMP)
  - Filled positions reported post-Match (mid-to late March report) – final approvals, early May
  - Flexibility to adjust throughout the year if positions are available

**VA funding: Underlying philosophy**

- VA is *not* paying for residents’ “service” or “work”, but participates in support of their training
- Resident positions reimbursed to the extent that assigned residents engage in VA-approved educational activities
- Education is part of VA’s mission!

**What does VA fund?**

- **DIRECT COSTS:** Paid by Disbursement Agreement or directly to residents
  - Resident and Fellow Stipends
  - Fringe Benefits (accruing to the individual)
- **INDIRECT COSTS:** paid by Veterans Equitable Resource Allocation (VERA) to facilities to cover:
  - Attending Contributions
  - VA Program Administration
  - Higher complexity care in teaching hospitals

**What GME costs does VA fund?**

- **DIRECT COSTS:** Stipends
  - Salary rates determined by each affiliate, can include Chief Resident differential
  - Stipends cover all time spent at VA in ACGME/AOA-approved activities
    - Clinical—inpatient and outpatient
    - Didactics
    - Scholarly activities, including research
    - General and subspecialties
    - Continuity clinics (reciprocity options)
  - Fully funds accredited resident AND fellowship years

**Concept: “Fencing” of Trainee Funding**

- VA trainee funding is “ear-marked” or “fenced.”
  - In practice, this means *these funds may not be used by a VA facility for any other purpose!*
- Trainee funds require careful cost accounting and unused $$ must be returned to OAA.
What does VA fund?

- DIRECT COSTS: Fringe Benefits
  - FICA – Social Security and Medicare tax
  - Health Insurance
  - Life Insurance
  - Disability Insurance
  - Worker’s Compensation
  - Retirement (only if vested)
  - Other individually approved items such as housing, parking, & lab coats or uniforms, provided they are required by the program & provided to all residents in the program or PGY.

Indirect Costs

- VA cannot pay indirect educational costs to affiliates via a disbursement agreement
- Policy in concurrence to allow VA to reimburse some education costs to affiliates via contract. E.g.,
  - Accreditation fees, ACLS certification, NRMP fees, in-service exams, pagers/cell phones, GME mgt software, etc.

What VA cannot pay to an affiliate (even under a contract)...

- Salaries/benefits of faculty or admin staff based at the affiliate
- Affiliate’s cost of running the GME/GDE office (we have our own admin costs!)
- Resident license fees
- Licensing exam fees-e.g., USMLE
- Resident board exam fees
- Malpractice insurance
- Recruitment or orientation expenses that involve meals, travel, or entertainment.

VA Indirect Costs: VERA

- VERA Educational supplement pays ‘indirect’ costs to VA teaching hospitals
  - Currently VA uses $83K/physician resident - as surrogate for all trainees
  - Goes to the VA medical center as “Medical Care” funding
  - Not ‘ear-marked’, like trainee funds

CMS Definitions & Funding of GME (1)

- DGME (direct GME costs): salaries & fringe benefits of residents & supervision plus program overhead costs
  - Resident count: Based upon creditable resident time
    - Balanced Budget Act (BBA) of 1997 (Pub. L. 105-33) – limited the # of residents a hospital can count for payment (i.e., “caps” – prior to 12/31/1996)
  - PRA (per resident amount):
    - Divides allowable costs by the # of residents in the BASE period (FY 1984)
  - DGME — calculated by multiplying PRA X (weighted # FTE residents working in hospital & allowed non-hospital sites) X (hospital’s Medicare share of total inpatient days)

CMS Definitions & Funding of GME (2)

- IME (indirect GME costs):
  - Intended to compensate for patient care costs of teaching hospitals relative to non-teaching hospitals
  - IME adjustment factor calculated by a hospital’s ratio of residents to beds, “r”, & a multiplier, “c” (set by Congress), in the following equation: c x [(1 + r).405 - 1].
  - DSH (disproportionate share hospital):
    - for large urban hospitals with >30% total net inpt revenues from State & local gov’ts for indigent care [alternate calc. using SSI* or if >15% indigent, can get a DSH adjustment]

VA vs. Medicare: Comparison (1)

<table>
<thead>
<tr>
<th>Cost center</th>
<th>VA</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient rotations</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient rotations</td>
<td>Yes</td>
<td>Possible under ACA*(called ‘non-hospital’)</td>
</tr>
<tr>
<td>Scholarly activities, incl. Research</td>
<td>Yes</td>
<td>Yes for DGME; No for IME**</td>
</tr>
<tr>
<td>Academic coursework (e.g., MPH degree)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Didactics &amp; orientation</td>
<td>Yes</td>
<td>Yes for DGME; if non-hospital, no for IME</td>
</tr>
<tr>
<td>Subspecialty fellowship years</td>
<td>Yes, fully</td>
<td>Yes, half direct costs</td>
</tr>
<tr>
<td>Resident supervision</td>
<td>VA Staff physicians</td>
<td>Direct costs intended to cover (but may be inadequate)</td>
</tr>
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*New rule allows payment of DGME & IME, with documentation that the sponsoring institution bears costs of GME **Except when research is directed towards the treatment of a particular patient.

VA vs. Medicare: Comparison (2)

<table>
<thead>
<tr>
<th>Cost Center</th>
<th>VA</th>
<th>Medicare</th>
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<tbody>
<tr>
<td>Remedial training</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Chief Residents, past core training</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Non-accredited fellowships</td>
<td>No*</td>
<td>No</td>
</tr>
<tr>
<td>Inflation adjustments, stipends</td>
<td>Yes</td>
<td>Yes, 2-yr (1996 &amp; ’97) $ for “primary care”</td>
</tr>
<tr>
<td>Vacation time</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Quality &amp; safety projects</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Off-site rotations</td>
<td>No, with limited exceptions**</td>
<td>No (receiving hospital can claim)***</td>
</tr>
</tbody>
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*Exception: VA-approved Advanced Fellowships (non-accredited) **Reciprocal funding of continuity clinics; ‘educational details’ possible for training required by ACGME, but not available at any participating hospital ***Each hospital counts proportionate share of time, when multiple hospitals incur costs

VA vs. Medicare: Comparison (3)

<table>
<thead>
<tr>
<th>Estimates – FY 2010</th>
<th>VA</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Direct” GME Funding*</td>
<td>$0.6 Billion</td>
<td>$3.0 Billion</td>
</tr>
<tr>
<td>“Indirect” GME Funding*</td>
<td>$0.7 Billion</td>
<td>$6.5 Billion</td>
</tr>
<tr>
<td>Total GME Funding:</td>
<td>$1.3 Billion</td>
<td>$9.5 Billion</td>
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*As previously noted: these categories are not strictly comparable.

Summary: VHA Funding of GME

- VA makes a significant contribution to GME funding & resident education nationwide. 2nd only after CMS.
- VA’s funding methodology differs significantly from Medicare’s.
- VA funding of GME (on a per resident basis) is more generous than CMS in a number of respects.

GME Enhancement (2006-10): Goals

- Address physician shortages
  - by expanding resident positions in specialties of greatest need to Veterans and the Nation
- Address the uneven geographic distribution of residents in VA
  - to improve access to care
- Foster innovative models of education
  - while enhancing VA’s leadership role in GME

Approved Positions by RFP

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<tr>
<th>RFP</th>
<th>Approved New Positions (2006 – 10)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>2006</td>
</tr>
<tr>
<td>Critical Needs &amp; Emerging Specialties</td>
<td>300</td>
</tr>
<tr>
<td>New Affiliations &amp; New Sites of VA Care</td>
<td>42</td>
</tr>
<tr>
<td>Educational Innovation</td>
<td>(N/A)</td>
</tr>
<tr>
<td>Rural Health Training</td>
<td>(N/A)</td>
</tr>
<tr>
<td>Totals</td>
<td>342</td>
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* Plus: 19 Association Health positions 15 Dental Resident positions
Example of a Rural ‘Success Story’

- Salisbury VAMC – in rural NC
  - Nearest affiliate: 30 to 40-minute commute (Wake Forest)
  - Major commitment by VISN & facility to improve faculty, staff, & infrastructure
  - Through “New Affiliations” & “Rural Health Training” RFPs, Salisbury went from:
    - 3.4 resident positions in 2006 to 54 in 2012
  - 75% of Salisbury’s RHT survey respondents say they’d be willing to consider working in a rural practice setting

VA GME Initiatives (1)

- Chief Residents in Quality & Pt Safety
  - 25 CRQS positions at 20 sites
  - Expansion & National Curriculum
- Rural Health Training Initiative
  - 4 sites phase I
  - Phase II project planning & new RFP
- Designated Educ. Officer (DEO)
  - Orientation
  - New role definition & staffing guidelines
- ‘Activation’ sites – new or expanding VA teaching facilities

VA GME Initiatives (2)

- Resident Supervision Index (RSI)
- Resident Education Index (REI)
- Facility readiness to meet 2011 ACGME Common Prgm Requirements
- Centers of Excellence in Education:
  - Primary Care (5 x 5 years)
  - Pt-centered Specialty Care (3 x 3 yrs)
- Interprofessional training focus

Summary & Conclusions

- VA has played a significant role in funding VA
  - The only Federal agency increasing funding for GME
  - Trains 30% of all US residents/year
- Innovative approaches to GME & interprofessional education & care delivery
- VA remains committed to expansion of training in rural sites

Questions?

Veterans Health Administration
Education Mission
To educate for VA and for the Nation

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http://www.va.gov/oaa