From Community Hospital to Teaching Hospital

Why you should start a graduate medical education program at your hospital

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Disclosure and Career

President Elect (4/13/26) of the American College of Osteopathic Family Physicians (ACOFP) representing 29,000 osteopathic family physicians in the United States.

No other disclosures.

Career

Dean and academic medicine 20 years.

Practice Family Medicine, Emergency Medicine and Aerospace Medicine as a USAF Flight Surgeon - 40 years.

Consultant for Graduate Medical Education Development for the American Osteopathic Association and former Dean of Post Doctoral Education and Development and GME 20 years.

Former Family Medicine Residency Program Director, Former Medical Director of 27 clinics for HCA in Denver and former Vice President and Chief Medical Officer of Community Based Teaching Hospital in Michigan.

What is graduate medical education (GME)?

GME, most often called residency, is the on-the-job specialty training physicians receive after they graduate from medical school. Fellows are advanced training and are subspecialists (cardiologists, colorectal surgeons).

As of January 2020, physicians must complete three years of residency to be licensed to practice medicine in most states.

Completing a residency is also a requirement to become board certified in a particular specialty (for example, family medicine, general surgery, or psychiatry).

Why should you consider starting a GME program?

WORKFORCE!

- Most areas of Iowa are experiencing a shortage of physicians in most specialties, but the workforce is particularly limited in primary care, obstetrics, general surgery and psychiatry.
- In addition, more than a third of the current physician workforce is age 60 or older.
- Recruiting doctors has become challenging—and expensive—in many Iowa communities

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GME offers the opportunity to "grow your own."

Studies show that most physicians work within 100 miles of where they finished their residency training.

Iowa has particularly fertile soil for retaining physicians, as most physicians who train in Iowa stay in Iowa.

Well, if it's so great, why isn't every hospital a teaching hospital?

Starting a new GME program at a hospital that's never had one requires substantial investment.

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GME Funding

Centers of Medicare/Medicaid Services (CMS) allocates $17.6 billion a year

Medicaid GME payments nationally $4.7 to $7.4 billion

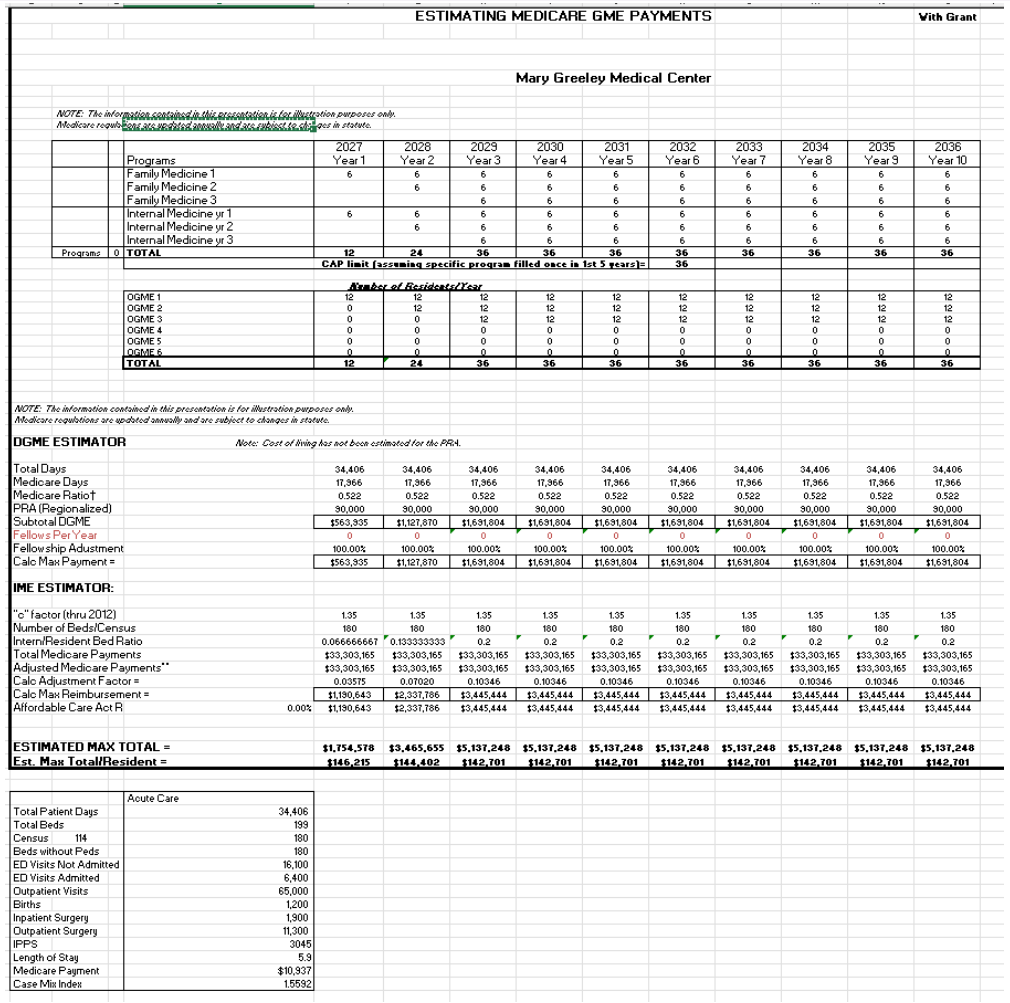
Veterans Affairs (VA) GME Funding $850 million annually

Programs that are financially breakeven or better receive about $140,000 per resident per year

GME Direct Funding and GME Indirect Funding

Capital GME Start Up Funding

GME Funding



ESTIMATING MEDICARE GME PAYMENTS — With Grant

Mary Greeley Medical Center

NOTE: The information contained in this presentation is for illustration purposes only.
Medicare regulations are updated annually and are subject to changes in statute.

		Programs	2027 Year 1	2028 Year 2	2029 Year 3	2030 Year 4	2031 Year 5	2032 Year 6	2033 Year 7	2034 Year 8	2035 Year 9	2036 Year 10
		Family Medicine 1	6	6	6	6	6	6	6	6	6	6
		Family Medicine 2		6	6	6	6	6	6	6	6	6
		Family Medicine 3			6	6	6	6	6	6	6	6
		Internal Medicine yr 1	6	6	6	6	6	6	6	6	6	6
		Internal Medicine yr 2		6	6	6	6	6	6	6	6	6
		Internal Medicine yr 3			6	6	6	6	6	6	6	6
Programs	0	**TOTAL**	**12**	**24**	**36**	**36**	**36**	**36**	**36**	**36**	**36**	**36**
		CAP limit (assuming specific program filled once in 1st 5 years)=						**36**				
					Number of Residents/Year							
		OGME 1	12	12	12	12	12	12	12	12	12	12
		OGME 2	0	12	12	12	12	12	12	12	12	12
		OGME 3	0	0	12	12	12	12	12	12	12	12
		OGME 4	0	0	0	0	0	0	0	0	0	0
		OGME 5	0	0	0	0	0	0	0	0	0	0
		OGME 6	0	0	0	0	0	0	0	0	0	0
		TOTAL	**12**	**24**	**36**	**36**	**36**	**36**	**36**	**36**	**36**	**36**

NOTE: The information contained in this presentation is for illustration purposes only.
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DGME ESTIMATOR *Note: Cost of living has not been estimated for the PRA.*

Total Days	34,406	34,406	34,406	34,406	34,406	34,406	34,406	34,406	34,406	34,406
Medicare Days	17,966	17,966	17,966	17,966	17,966	17,966	17,966	17,966	17,966	17,966
Medicare Ratio†	0.522	0.522	0.522	0.522	0.522	0.522	0.522	0.522	0.522	0.522
PRA (Regionalized)	90,000	90,000	90,000	90,000	90,000	90,000	90,000	90,000	90,000	90,000
Subtotal DGME	$563,935	$1,127,870	$1,691,804	$1,691,804	$1,691,804	$1,691,804	$1,691,804	$1,691,804	$1,691,804	$1,691,804
Fellows Per Year	0	0	0	0	0	0	0	0	0	0
Fellowship Adustment	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Calc Max Payment =	$563,935	$1,127,870	$1,691,804	$1,691,804	$1,691,804	$1,691,804	$1,691,804	$1,691,804	$1,691,804	$1,691,804

IME ESTIMATOR:

"c" factor (thru 2012)	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35	1.35
Number of Beds/Census	180	180	180	180	180	180	180	180	180	180
Intern/Resident Bed Ratio	0.066666667	0.133333333	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Total Medicare Payments	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165
Adjusted Medicare Payments**	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165	$33,303,165
Calc Adjustment Factor =	0.03575	0.07020	0.10346	0.10346	0.10346	0.10346	0.10346	0.10346	0.10346	0.10346
Calc Max Reimbursement =	$1,190,643	$2,337,786	$3,445,444	$3,445,444	$3,445,444	$3,445,444	$3,445,444	$3,445,444	$3,445,444	$3,445,444
Affordable Care Act R 0.00%	$1,190,643	$2,337,786	$3,445,444	$3,445,444	$3,445,444	$3,445,444	$3,445,444	$3,445,444	$3,445,444	$3,445,444
ESTIMATED MAX TOTAL =	**$1,754,578**	**$3,465,655**	**$5,137,248**	**$5,137,248**	**$5,137,248**	**$5,137,248**	**$5,137,248**	**$5,137,248**	**$5,137,248**	**$5,137,248**
Est. Max Total/Resident =	**$146,215**	**$144,402**	**$142,701**	**$142,701**	**$142,701**	**$142,701**	**$142,701**	**$142,701**	**$142,701**	**$142,701**

	Acute Care
Total Patient Days	34,406
Total Beds	199
Census 114	180
Beds without Peds	180
ED Visits Not Admitted	16,100
ED Visits Admitted	6,400
Outpatient Visits	65,000
Births	1,200
Inpatient Surgery	1,900
Outpatient Surgery	11,300
IPPS	3045
Length of Stay	5.9
Medicare Payment	$10,937
Case Mix Index	1.5592

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DGME ESTIMATOR *Note: Cost of living has not been esti*

Total Days		34,406
Medicare Days		17,966
Medicare Ratio†		0.522
PRA (Regionalized)		90,000
Subtotal DGME		$563,935
Fellows Per Year		0
Fellowship Adustment		100.00%
Calc Max Payment =		$563,935

IME ESTIMATOR:

"c" factor (thru 2012)		1.35
Number of Beds/Census		180
Intern/Resident Bed Ratio		0.066666667
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Adjusted Medicare Payments**		$33,303,165
Calc Adjustment Factor =		0.03575
Calc Max Reimbursement =		$1,190,643
Affordable Care Act Rec	0.00%	$1,190,643
ESTIMATED MAX TOTAL =		**$1,754,578**
Est. Max Total/Resident =		**$146,215**

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Direct GME Funding

DGME supports costs that are directly attributable to residency education, including:

- Resident and fellow salaries and benefits
- Faculty teaching time (portion attributable to education)
- Program administration (program directors, coordinators)
- Educational infrastructure (didactics, evaluation systems)
- GME office expenses

Why DGME Exists

- Teaching hospitals incur real, measurable educational expenses
- Residents are not simply employees; they require supervision, faculty time, and infrastructure
- Without DGME, hospitals would have little financial incentive to absorb these direct training costs

Indirect GME Funding

Indirect Medical Education funding is an add-on payment to Medicare inpatient reimbursement recognizing that teaching hospitals have higher patient care costs because they train residents.

IME is not cost-reimbursement—it is an adjustment factor applied to Medicare inpatient payments.

What IME Accounts For

- IME reflects system-level inefficiencies and complexities inherent to teaching hospitals, such as:
  - Increased diagnostic testing and consultations
  - More complex, sicker patient populations
  - Longer lengths of stay
  - Slower clinical throughput due to supervision and education
  - Greater use of advanced technology and subspecialty services
  - 24/7 availability of specialists and trainees

Capital Start-Up Funds (in GME)

Capital start-up funds are one-time (or time-limited) investments used to create the physical, operational, and accreditation infrastructure required to launch a new residency or fellowship program.

They are not operating funds and are not Medicare reimbursements.

Instead, they are front-end investments that allow a hospital or health system to become *capable* of training residents.

Why Capital Start-Up Funds Are Necessary

Medicare DGME and IME:

- Do not begin until residents are enrolled
- Do not pay retroactively
- Do not cover construction, major equipment, or accreditation start-up
- Yet, hospitals must incur substantial costs before the first resident ever arrives, including:
- Accreditation preparation (ACGME)

Program leadership hiring

- Clinical infrastructure upgrades
- Educational space development
- IT and compliance systems
- Capital start-up funding exists to bridge this pre-residency financial gap.

Capital start-up funding exists to bridge this pre-residency financial gap.

Many expenses related to starting a GME program are up-front costs

Outside consulting
(feasibility studies, financial expertise, legal support)

Infrastructure improvements
(resident call rooms, workstations, simulators)

Personnel
(program coordinators, program directors)

Accreditation fees

Program costs before reimbursements become available, such as resident salaries and insurance

Strategies to Overcome Startup Costs

Startup Grants

- Song Brown Grant
- CalMedForce programs

Both programs got substantial funding from a tobacco tax in California.

Early funding came from general fund and an assessment on physician license fees.

Nonfinancial barriers are also substantial

Hospitals must also meet all the requirements for accreditation:

- Appropriate access to different educational experiences
- Appropriate number and types of patients

Qualified program directors and designated institutional officials can be difficult to find and recruit.

Support from the medical and support staff might be mixed, particularly in the beginning (people don't like "giving up ownership and control" to residents).

The accreditation process can be lengthy, often taking two years or more.

Iowa Hospitals Potentially Supporting GME

Hospital Name	Gross Revenue	Discharges	Beds	Acute Care Census	City	State	Total Patient Days	Medicare Payment	Case Mix Index	Estimated Per Resident Amount Bedcount	Estimated Per Resident Amount Census 10%	FM	IM	CAHSE	Rural	Rural Referral
University of Iowa Hospitals & Clinics	$7,631,860,203.00	31,951	800	671	Iowa City	IA	220,210	$ 24,062	2.6293	$ 150,539	$ 161,068	8	31	685		
UnityPoint Health - Iowa Methodist Medical Center	$3,430,039,290.00	34,844	631	521	Des Moines	IA	175,410	$ 13,761	1.8878	$ 138,531	$ 149,475		12	98	Rural	Y
MercyOne Des Moines	$3,232,666,835.00	28,052	591	384	Des Moines	IA	143,393	$ 15,560	2.3132	$ 115,347	$ 151,293	10		59	Urban	N
Genesis Medical Center, Davenport, East Rusholme Street	$1,338,233,081.00	16,728	359	189	Davenport	IA	62,555	$ 13,155	1.8689	$ 118,142	$ 178,850	6		18	Rural	Y
Southeast Iowa Regional Medical Center, West Burlington Campus	$849,712,781.00	5,220	357	81	Burlington	IA	25,015	$ 13,791	1.6277	$ 100,098	$ 234,748			0	Rural	Y
UnityPoint Health -Saint Luke's Hospital Cedar Rapids**4 Residents	$1,253,340,256.00	12,573	314	186	Cedar Rapids	IA	59,252	$ 13,753	1.9579	$ 116,767	$ 161,132			4	Urban	N
Mercy Medical Center	$1,572,102,110.00	8,925	238	129	Cedar Rapids	IA	42,609	$ 11,750	1.6218	$ 128,938	$ 187,283			0	Urban	N
MercyOne North Iowa	$1,446,140,448.00	8,447	233	112	Mason City	IA	39,918	$ 13,343	1.7758	$ 161,000	$ 257,754	6	6	45	Rural	Y
University of Iowa Health Care Medical Center Downtown	$640,952,307.00	4,751	211	100	Iowa City	IA	20,445	$ 11,384	1.755	$ 86,336	$ 130,651			0	Urban	N
UnityPoint Health - Allen Hospital**Rural	$811,928,931.00	9,848	201	121	Waterloo	IA	42,047	$ 12,357	1.9595	$ 114,841	$ 156,002			8	Rural	Y
Mary Greeley Medical Center	$697,080,583.00	8,356	199	114	Ames	IA	34,406	$ 10,937	1.5592	$ 134,340	$ 182,192			0	Urban	N
UnityPoint Health - Iowa Lutheran Hospital	$607,123,019.00	8,036	189		Des Moines	IA	38,353					9			Urban	N
MercyOne Waterloo Medical Center	$1,176,794,433.00	4,858	186	89	Waterloo	IA	28,908	$ 13,419	1.7045	$ 79,876	$ 122,961			14	Urban	N
UnityPoint Health - St. Lukes**Rural	$512,475,334.00	8,309	183	113	Sioux City	IA	42,667	$ 12,593	1.7956	$ 99,100	$ 130,805			10	Rural	Y
MercyOne Siouxland Medical Center	$545,007,496.00	5,692	167	95	Sioux City	IA	31,459	$ 14,845	2.0066	$ 156,424	$ 219,270	6		5	Urban	Y
MercyOne Dubuque Medical Center	$513,381,648.00	7,160	151	84	Dubuque	IA	29,161	$ 10,608	1.6676	$ 210,299	$ 296,781			0	Rural	Y
Saint Anthony Regional Hospital	$219,399,475.00	1,379	142	20	Carroll	IA	6,772	$ 9,649	1.3604	$ 66,548	$ 168,153			0	Rural	N
CHI Health Mercy Council Bluffs	$476,403,677.00	4,904	141	65.8	Council Bluffs	IA	23,999	$ 12,405	1.7411	$ 68,738	$ 109,689			0	Urban	N
Methodist Jennie Edmundson Hospital	$387,767,053.00	6,176	127	73	Council Bluffs	IA	26,666	$ 11,151	1.6158	$ 118,713	$ 165,042			1	Urban	N
Broadlawns Medical Center	$386,647,089.00	3,675	121	71.9	Des Moines	IA	25,897	$ 16,231	1.4426	$ 29,144	$ 36,673	8		1288	Urban	N
Ottumwa Regional Health Center	$336,729,732.00	1,459	120	30	Ottumwa	IA	6,018	$ 14,249	1.3772	$ 84,758	$ 162,074				Rural	N
Sioux Center Health Center	$87,126,241.00	559	118	5	Sioux Center	IA	2,506	$ 9,129	1.1533	$ 29,341	$ 97,582				Rural	N

However…
If, after some analysis, a hospital decides it has the capacity for a GME program, there can be MANY benefits.

Benefit #1 for hospitals starting a GME program for the first time

FEDERAL FUNDING

Hospitals that have never had a teaching program or have rural designation are eligible to draw substantial funding for new GME programs through Medicare. But the amount, as well as the number of residents that the Centers for Medicare & Medicaid Services will pay for, is LIMITED. There is also a LIMITED TIME period during which hospitals can set their maximum values after the process begins. This is one reason it is *crucial* to obtain financial expertise specific to Centers for Medicare & Medicaid Services cost reports in the early stages of planning, well before the clock starts ticking.

Though there are substantial start-up costs, many programs can become cost neutral *(or even generate revenue)* within 5 to 10 years.

Financials

							$175
	$4,083	$4,083	$4,083	$4,083	$4,083	$4,083	$4,083
Skills Assessment							$600
							$252
							$0
	$0	$0	$0	$0	$0	$0	$867
ducational Expenses/MPH							
sq/ft	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000
ation Expense							$2,250
& General	$14,083	$14,083	$14,083	$14,083	$14,083	$14,083	$21,137
	$45,583	**$45,583**	**$45,583**	**$45,583**	**$45,583**	**$45,583**	**$194,596**
							$16,216
	$0	$0	$0	$0	$0	$0	$146,215
	$45,583	$45,583	$45,583	$45,583	$45,583	$45,583	$194,596
	$0	$0	$0	$0	$0	$0	$0
	($45,583)	**($45,583)**	**($45,583)**	**($45,583)**	**($45,583)**	**($45,583)**	**($48,381)**
	($628,663)	**($674,247)**	**($719,830)**	**($765,413)**	**($810,997)**	**($856,580)**	**($904,961)**

	January	February	March	April	May	June	July	A
		Residency will develop a rank list for Match	Post Match OGME will submit the		Arrangements for record review, faculty	Final on-site review of program implementation	**Formal start of**	

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Benefit #2 And did we mention

Workforce

New teaching hospitals say that the cost of starting a GME program is neutral after costs of recruiting new physicians are considered. They also say that, ultimately, it is less expensive to train a new doctor than to hire a trained one.

New teaching hospitals say that physician recruitment is easier and that they can attract higher quality physicians after starting a teaching program.

Teaching programs create an immediate and long-term physician workforce pipeline, as some graduates each year choose to stay and work in the community.

Residents tend to be up to date with current standards of care, which can enhance the quality of care at the hospital.

Teaching programs increase physicians' quality of life, increasing job satisfaction and retention

Physician recruitment and retention

Teaching helps avoid physician burnout, promoting physicians' wellness and providing additional career satisfaction.

Residents often cover the less-desirable schedules and take care of the more mundane tasks.

Many physicians feel there is substantial prestige associated with a faculty position.

Teaching programs improve the clinical quality and reputation of the hospital

Improved hospital reputation

The public perception is that teaching hospitals offer higher quality care.

Faculty physicians stay updated with current standards of practice, including new standards in technology.

Residents often build positive relationships within the community, promoting the hospital.

Teaching hospitals can serve as innovation centers, implementing new care delivery models and producing graduates familiar with new models of care.

Residents reflect the organizational culture of their training institution, extending its reputation beyond the walls of the institution.

There are benefits to the community

Public health impact

Residents directly address physician shortages in regions with unmet need. Residents can also provide direct care to underserved, low-income, and vulnerable populations.

Regional economic impact

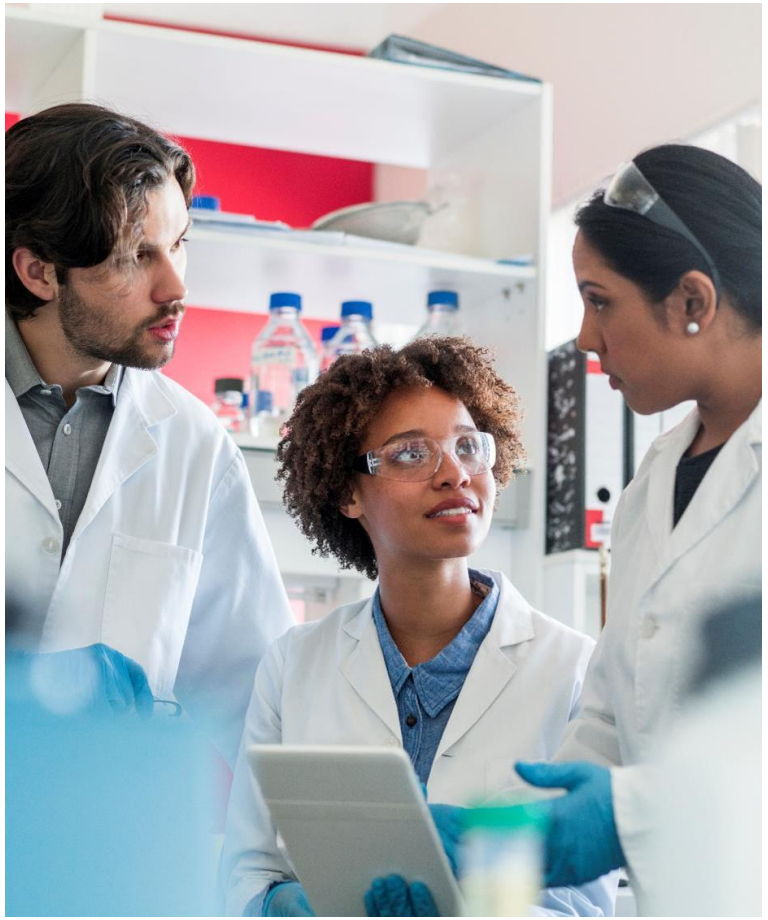
Regional impacts include an increase in business volume, the creation of jobs, and the generation of tax revenue for local and state governments. In 2019, strategic consulting firm Tripp Umbach estimated that in Georgia, each resident generates an average of $300,000 in regional tax revenue.

Sustainable economic impact

Tripp Umbach also estimated that, in Georgia in 2019, each resident physician who remains in the region generates $2.2 million of economic impact annually and, on average, creates 14 additional jobs.

What about typical cost centers like primary care and psychiatry? Won't they be a drain on a hospital's already limited resources?

- These fields can bring in indirect revenue or new service lines to other areas of the hospital.
- They can produce shared savings or cost avoidance by reducing community dependence on emergency department and readmissions.
- Published data show that teaching hospitals have less mortality than non-teaching hospitals, have a quicker time to see patients, and have higher patient satisfaction.
- Through improved chronic disease management, these fields can reduce high cost and low reimbursement care, including length of hospital stay and other operating costs.



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What This Means for Iowa Communities

Jennifer S. Beaty, MD, FACS, FASCRS
Associate Dean, Graduate Medical Education
Designated Institutional Official
Associate Professor, Surgery

What This Means for Iowa Communities

Workforce
Access
Patients

Why This Matters to Me

Colorectal Surgeon
Practiced in small town Iowa
Educator
Iowan

We have a Workforce Gap

Aging physicians

Shortages now

Rural Impact

Where Doctors Decide to Stay

Residency Training
Pipeline to Practice
Stay Near Training

OVERVIEW OF OPERATION I.O.W.A. – SOLUTIONS FOR IOWA'S PHYSICIAN WORKFORCE CRISIS

Below are the primary solutions put forward from state health leaders during the Operation I.O.W.A. summit, ranked in order of popularity and feasibility.

Seven Early-Career Physician Pipeline Solutions:

- Increase the number of residency training positions and provide financial support of medical educators across Iowa.

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Grow Our Own Physicians

Train in Iowa

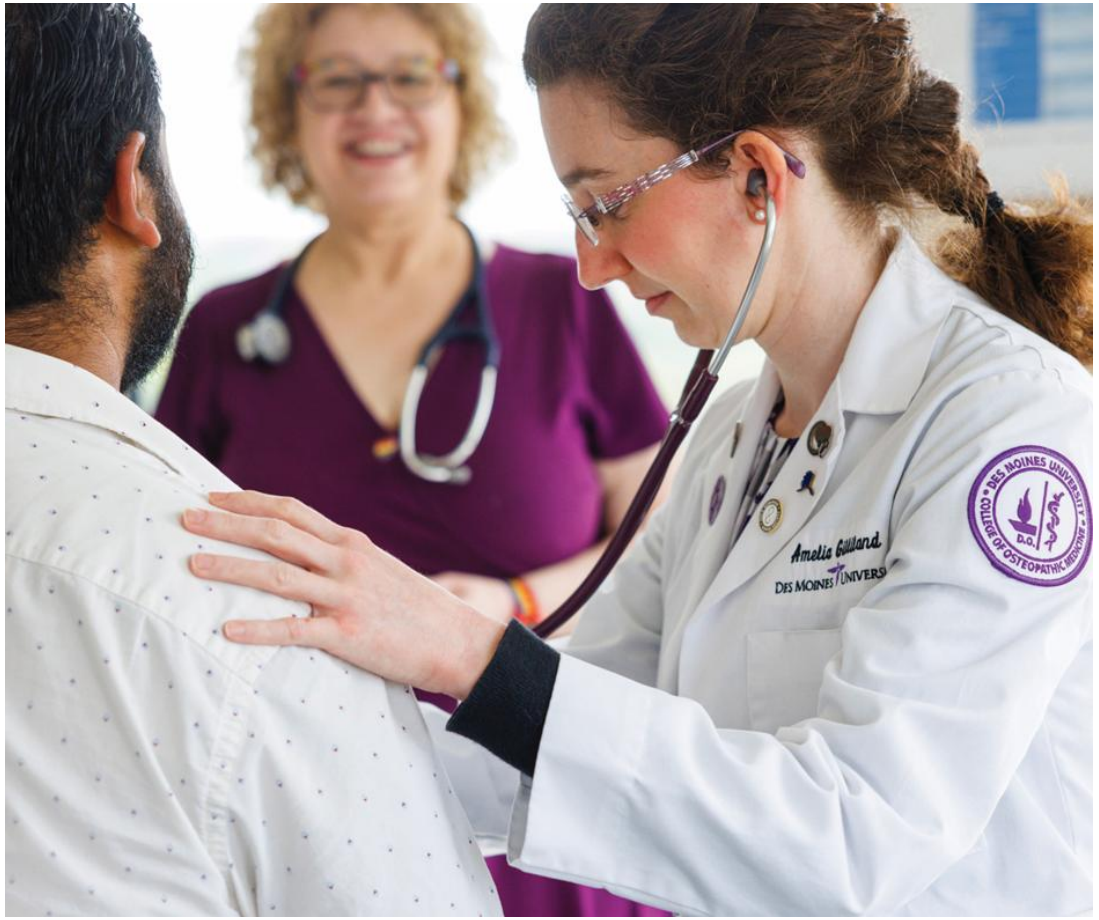
Practice in Iowa

Long-term Solution

What This Looks Like in Real Life

Patients waiting

Students who want to stay



What This Looks Like in Real Life

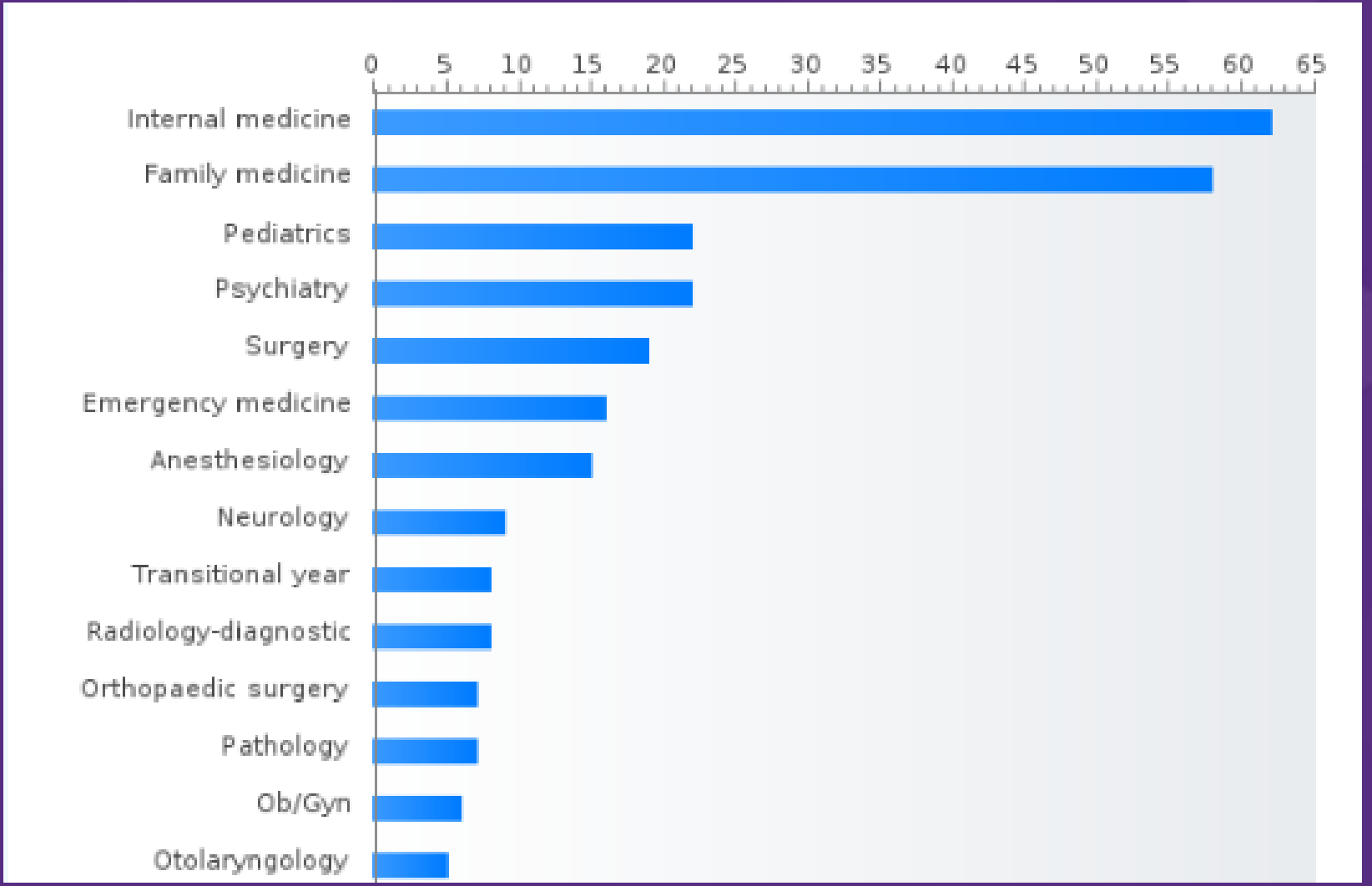
160: U of I

200: DMU

360 graduate med school/year

IOWA RESIDENCY POSTIONS	260 positions
Internal Medicine	62
Family Medicine	58
Pediatrics	22
Psychiatry	22
Surgery	19
Emergency Medicine	16
Anesthesia	15
Neurology	9
Radiology	8
Orthopedic Surgery	7
Pathology	7
Obstetrics and Gynecology	6
Otolaryngology	5
Neurological Surgery	2
Child Neurology	2

What This Looks Like in Real Life



What This Looks Like in Real Life in 2025

U of I: 41

DMO: 32

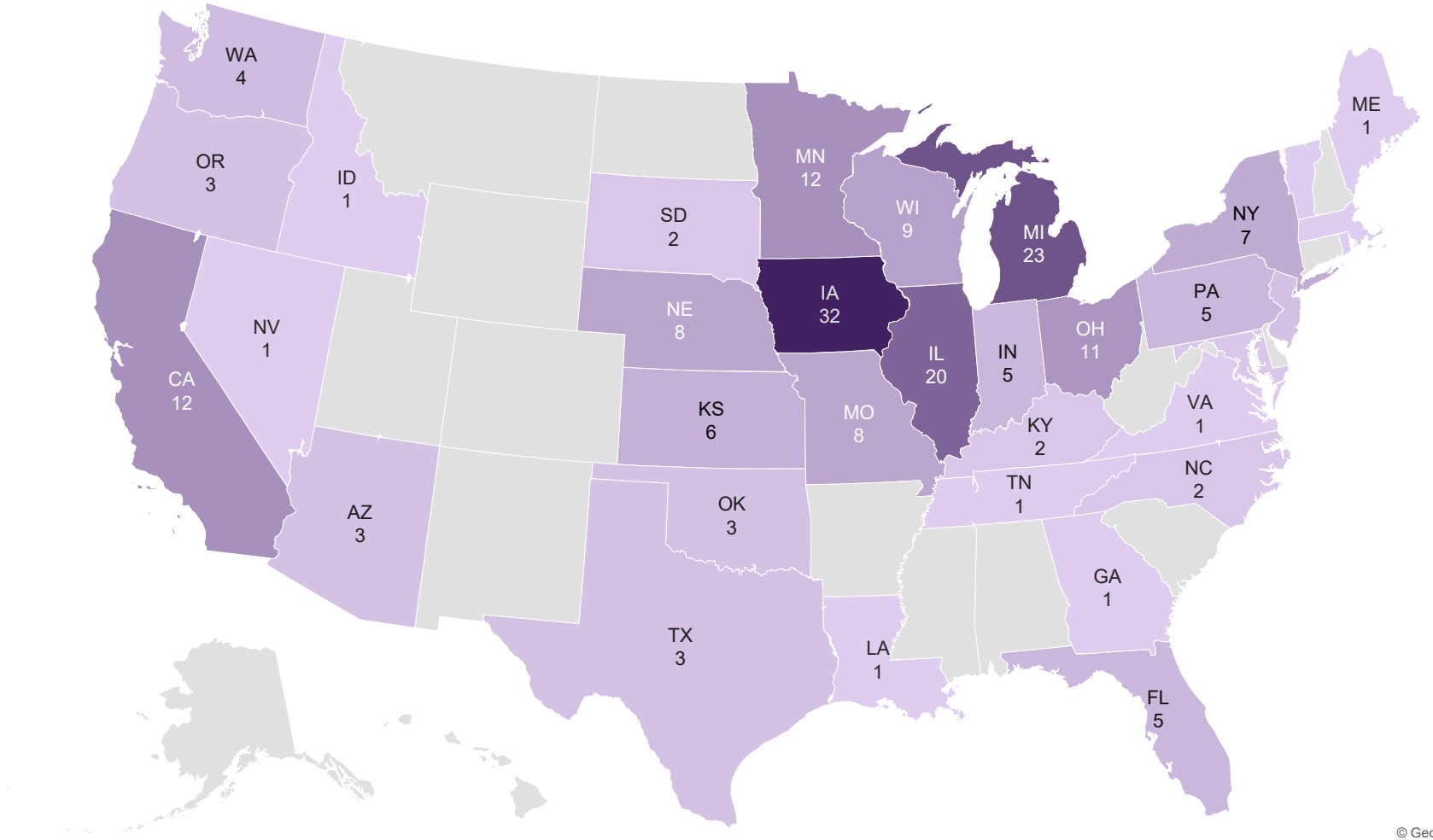
73 stayed in Iowa to train

What This Looks Like in Real Life in 2025

360 graduates per year
73 stay in Iowa

~200 LEFT IOWA to train

DMU COM Residency Matches 2025



What This Looks Like in Ob-gyn

6 OB-Gyn graduate in Iowa per year

57 open positions in Iowa

175 practicing OB-Gyns currently

Bridging the Gap

Startup costs

Federal funding follows

Makes programs possible

Where New Residencies Can Grow

Sioux City
Ames
Cedar Rapids
Burlington
Pella

Where New Residencies Can Grow

Proposed training sites

Statewide impact

Local workforce pipeline

A Smart Investment

Workforce stability

Economic impact

Better access

$750,000 Grant to Launch Programs

Catalytic funding

Unlocks federal $

Builds Pipeline

The Future for Iowa

Care close to home

Decrease wait times

Strong communities