

Unique & Alternative Funding Models for Academic Health Centers



Tomorrow's Doctors, Tomorrow's Cures®

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December 9, 2025

Learn

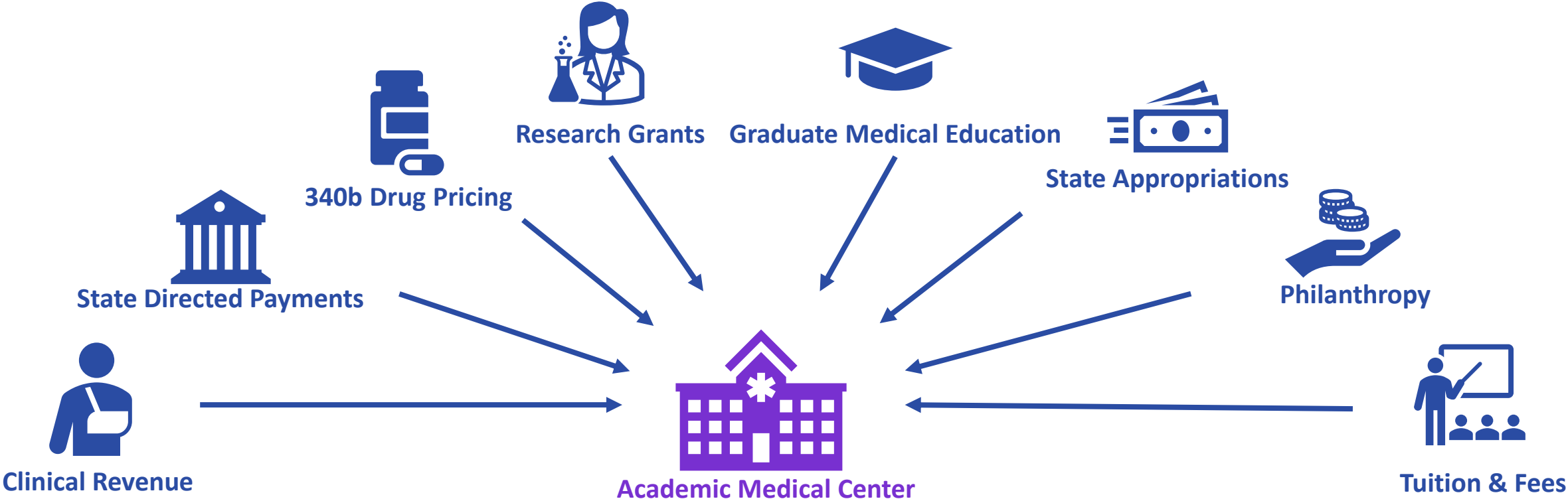
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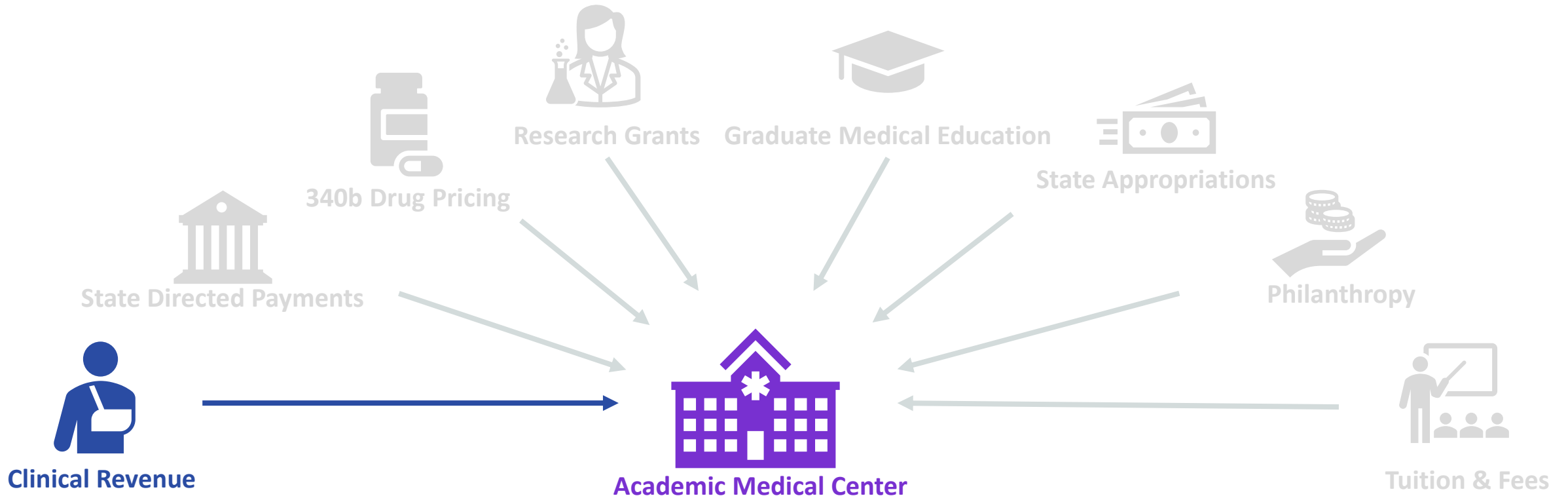


Association of
American Medical Colleges

Current Funding Pressures Threatening AMCs

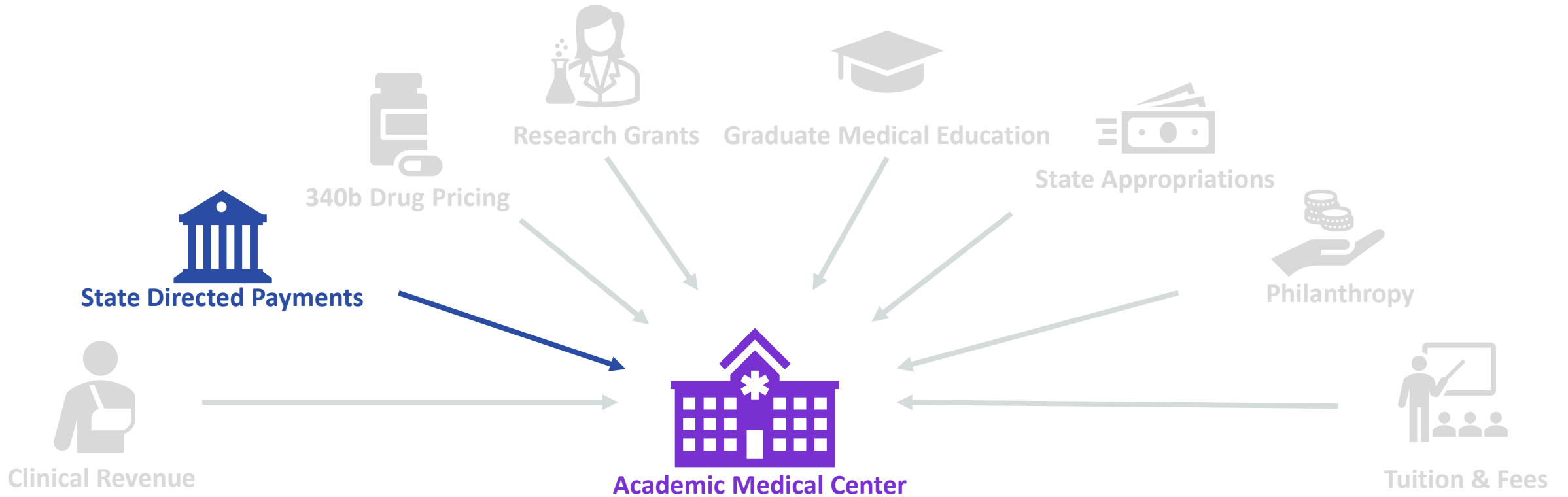


Current Funding Pressures Threatening AMCs



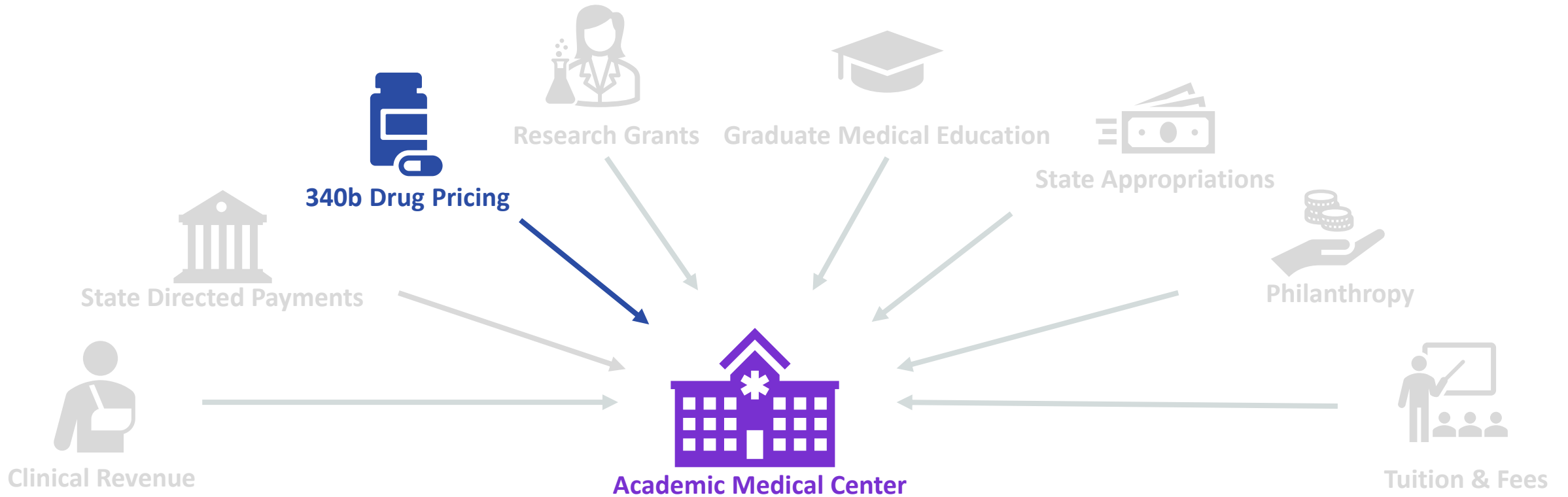
Source	<ul style="list-style-type: none"> • Payers (Medicare, Medicaid, Commercial), • Patients (out-of-pocket)
Current Pressure	<ul style="list-style-type: none"> • Reimbursement rates not keeping up with cost escalation • Some patients will lose Medicaid and become uninsured • Shift from Commercial to Government payors
Implications to AMC Funds Flow	<ul style="list-style-type: none"> • Need to bolster essential services with margin-generating, high commercial services to achieve break-even • Reduce or hold constant clinical support of research/teaching missions

Current Funding Pressures Threatening AMCs



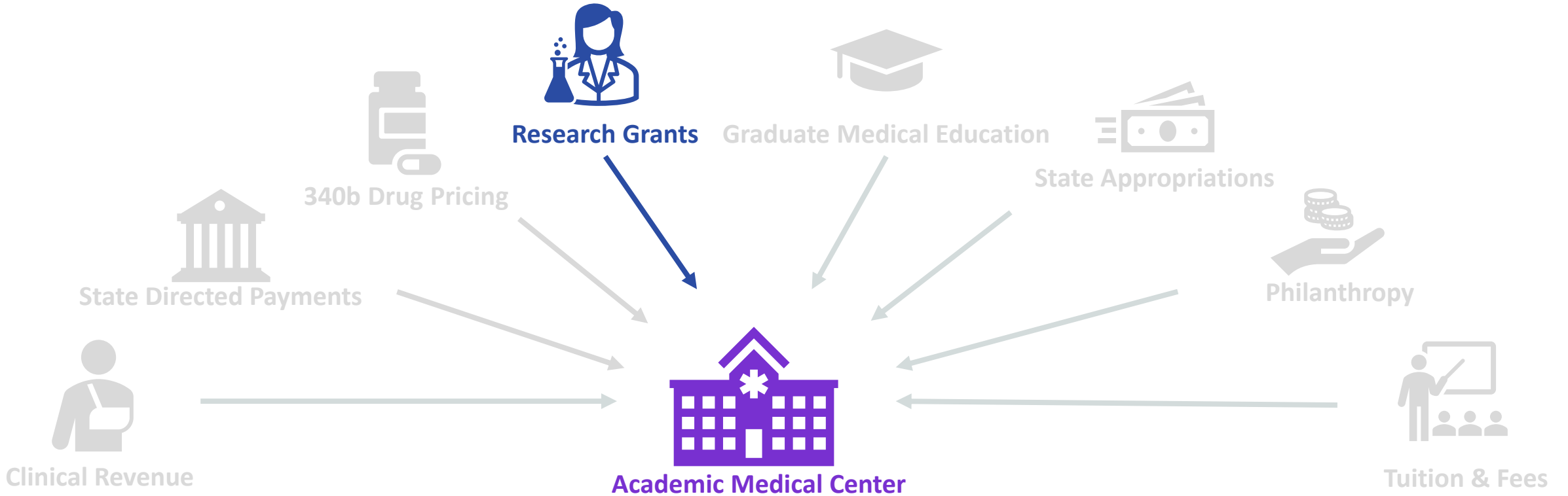
Source	<ul style="list-style-type: none"> • CMS • States
Current Pressure	<ul style="list-style-type: none"> • Federal funding reduced under OBBBA, placing greater burden on states with already-constrained budgets • Reduced discretion at state level to design SDP programs
Implications to AMC Funds Flow	<ul style="list-style-type: none"> • Reduced funding to hospitals will reduce clinical margins, meaning right-sizing clinical portfolio and payor mix, or cutting services • Reduced migration toward novel value-based arrangements

Current Funding Pressures Threatening AMCs



Source	<ul style="list-style-type: none"> Pharmaceutical Companies
Current Pressure	<ul style="list-style-type: none"> Pilot Rebate program will delay discounts for some drugs and introduce new administrative burden Pharma industry continues lobbying to restrict or eliminate 340b eligibility
Implications to AMC Funds Flow	<ul style="list-style-type: none"> Reduced cash-on-hand in order to “float” discounts and increase administrative expense Reduced margin for services with high drug spend like Cancer, GI, and Neurosciences Would reshape the economics for funding service line growth (e.g., hem/onc recruitment, PSAs), and specialty pharmacy strategy

Current Funding Pressures Threatening AMCs



Source

- NIH
- Foundations
- Industry

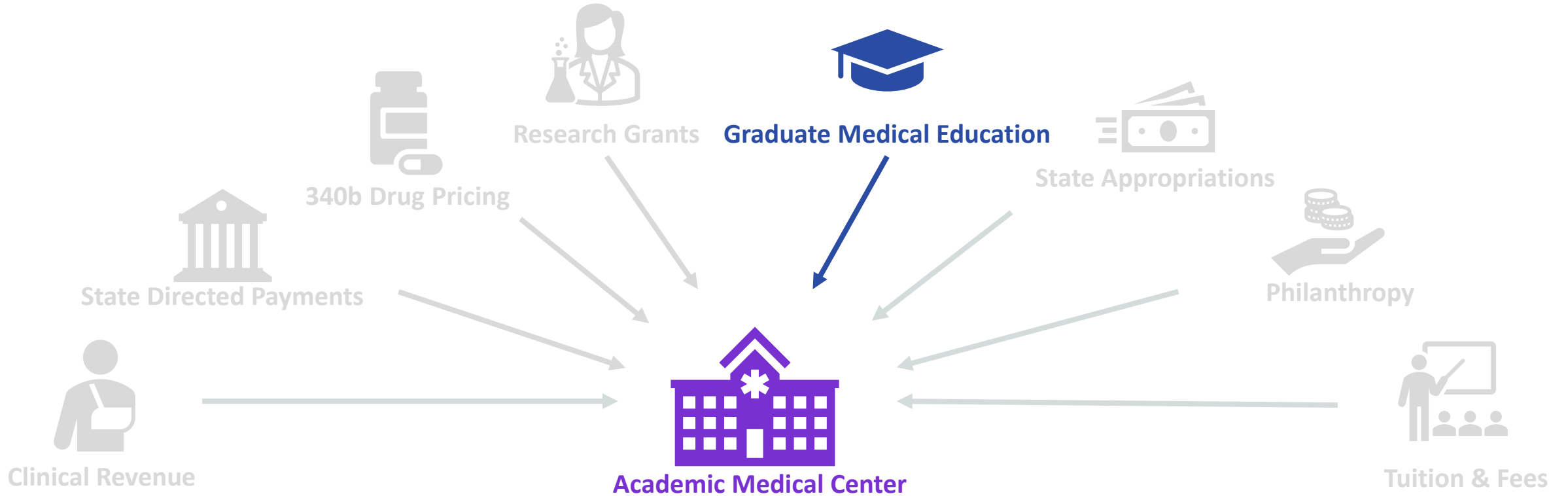
Current Pressure

- Stagnant federal research funding
- Possible cuts to indirect cost recovery
- Gov't freezing grants to select universities

Implications to AMC Funds Flow

- Emphasis on research efficiency
- Slowdown in capital funding for research infrastructure
- Diversification of sponsor mix

Current Funding Pressures Threatening AMCs



Source

- CMS
- Health systems (for slots above cap)

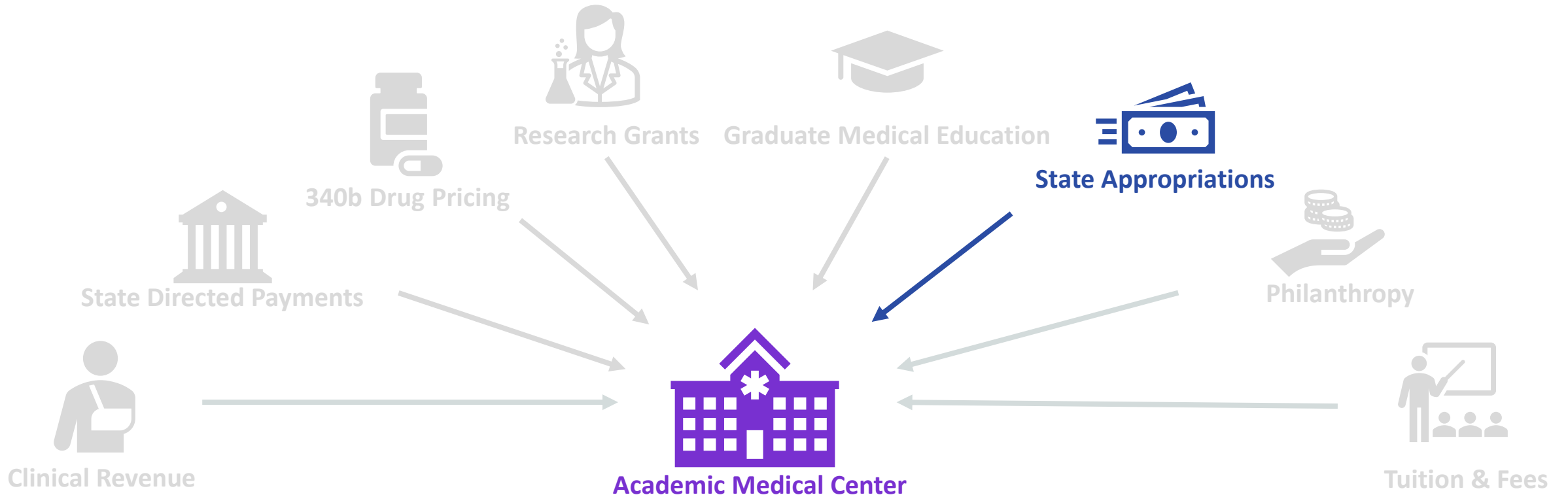
Current Pressure

- CMS cap frozen at 1997 levels despite pressure to grow training slots given rising demand
- Evolving accreditation and curricula requirements

Implications to AMC Funds Flow

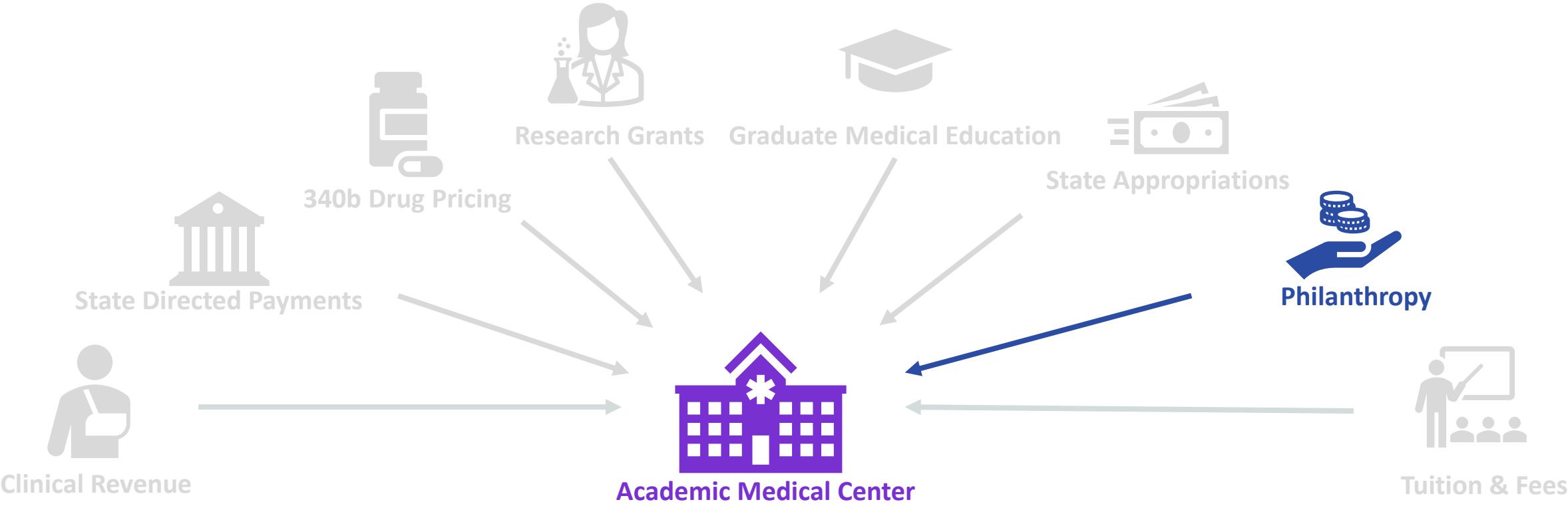
- AMCs cover a higher percentage of total GME expense
- More scrutiny of faculty effort needed for teaching

Current Funding Pressures Threatening AMCs



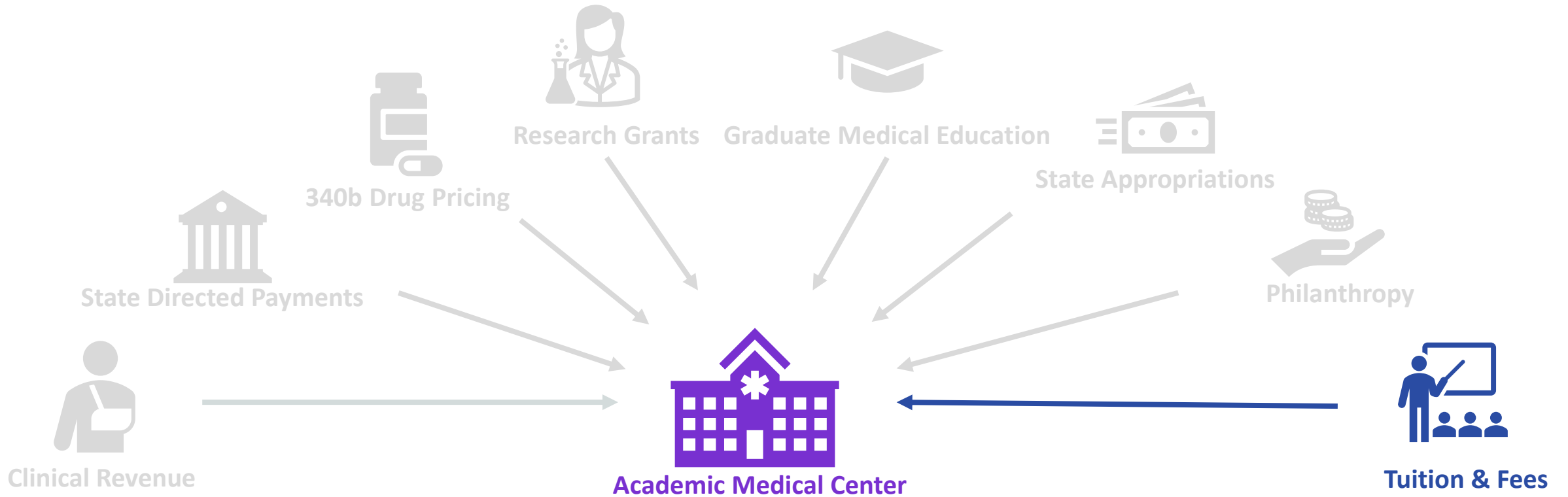
Source	<ul style="list-style-type: none"> • State governments (esp. public AMCs)
Current Pressure	<ul style="list-style-type: none"> • Declining/flat funding • Competing budget priorities • Politics
Implications to AMC Funds Flow	<ul style="list-style-type: none"> • Potential reductions in state support in key areas • Greater emphasis on lobbying/advocacy • AMC priorities tied to political interest • Tuition Increases

Current Funding Pressures Threatening AMCs



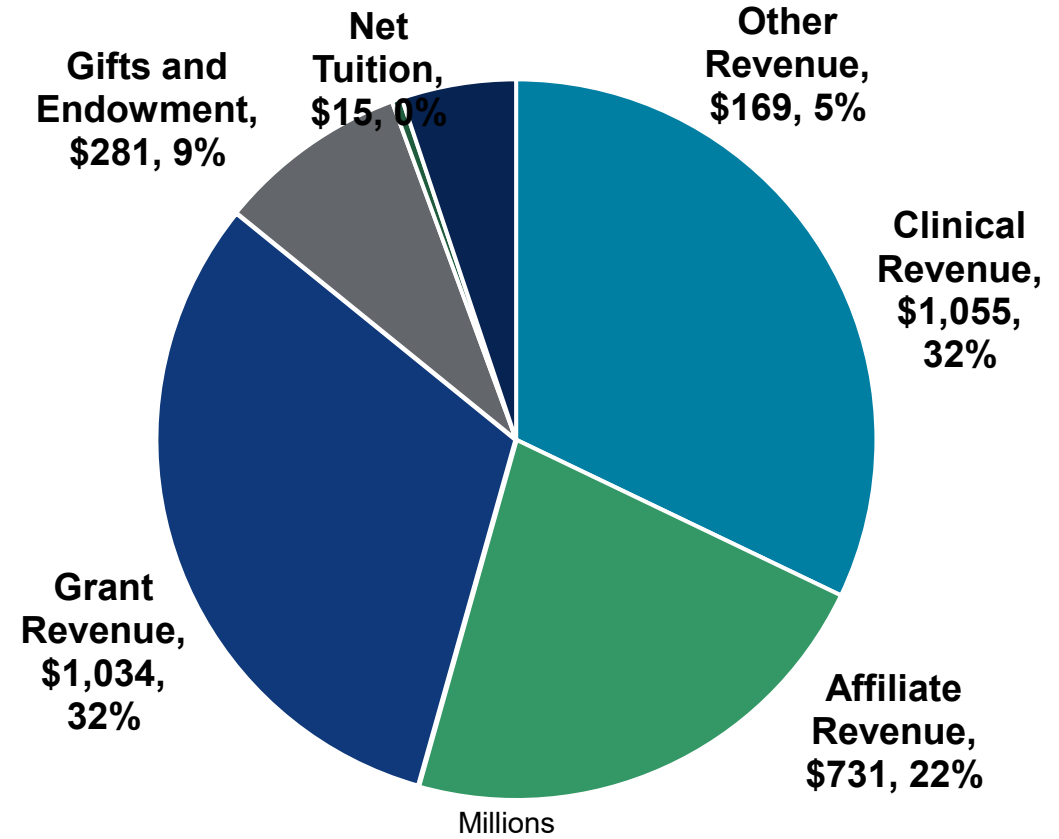
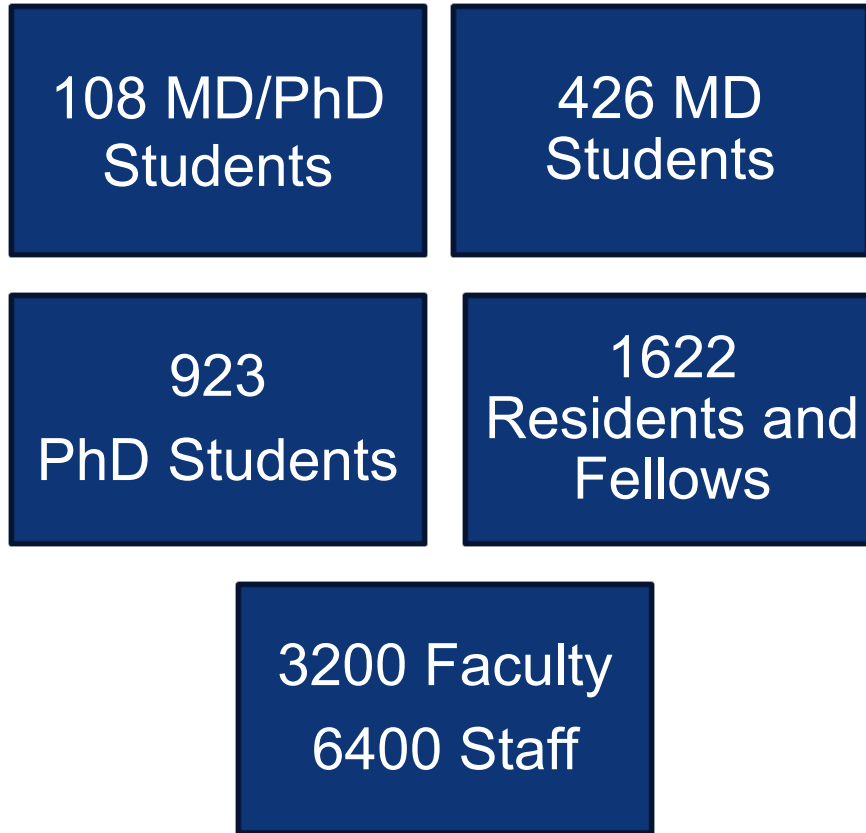
Source	<ul style="list-style-type: none"> • Donors • Alumni • Foundations
Current Pressure	<ul style="list-style-type: none"> • Unpredictable, and not evenly distributed • Non-profit status being questioned • Concerns of a recession
Implications to AMC Funds Flow	<ul style="list-style-type: none"> • Expansion of philanthropy function • Critical for diversification away from government sources • Difficult to budget long-term academic investments

Current Funding Pressures Threatening AMCs



Source	<ul style="list-style-type: none"> • Students • Financial Aid/Loans
Current Pressure	<ul style="list-style-type: none"> • Tuition increases have already strained affordability
Implications to AMC Funds Flow	<ul style="list-style-type: none"> • Educational revenue not keeping pace with cost of delivery • Faculty teaching effort undercompensated

Johns Hopkins School of Medicine | Stats and Revenue



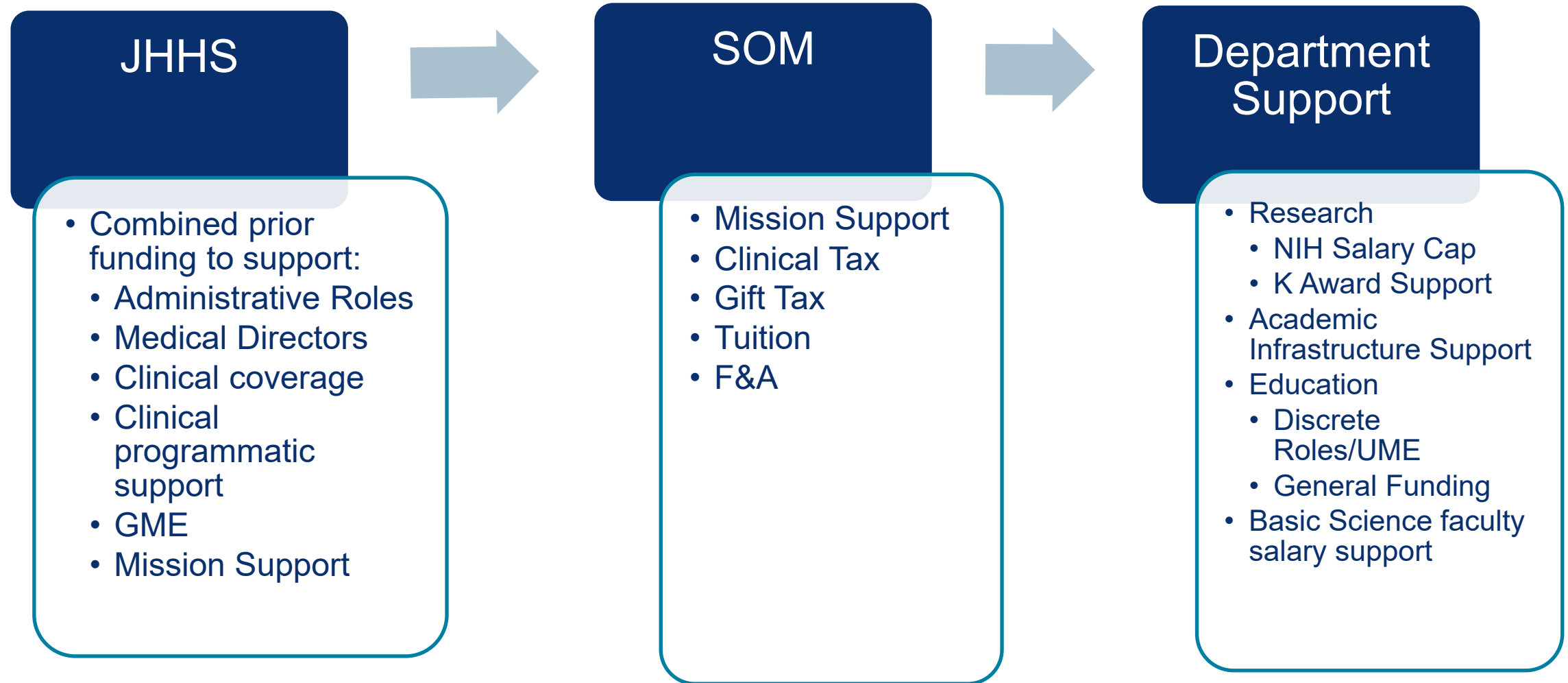
The need to change...

- Health system funds flow to clinical departments was defined as the historical “book of deals”
- Immense volume of agreements across multiple hospital entities
- Lack of standardization / consistency across agreement types and entities
- School was dealing with financial issues and went through a total financial transformation
- Scale and complexity of funding needs to appropriately support highly sub-specialized clinical programs across multiple sites, as well as one of the country’s largest research portfolios and a diverse set of sizable training programs
- Material disincentive at the department level to achieve stronger than expected bottom line financial performance as a result of the inaccessibility of margin after year end close

Journey 2022 to 2026

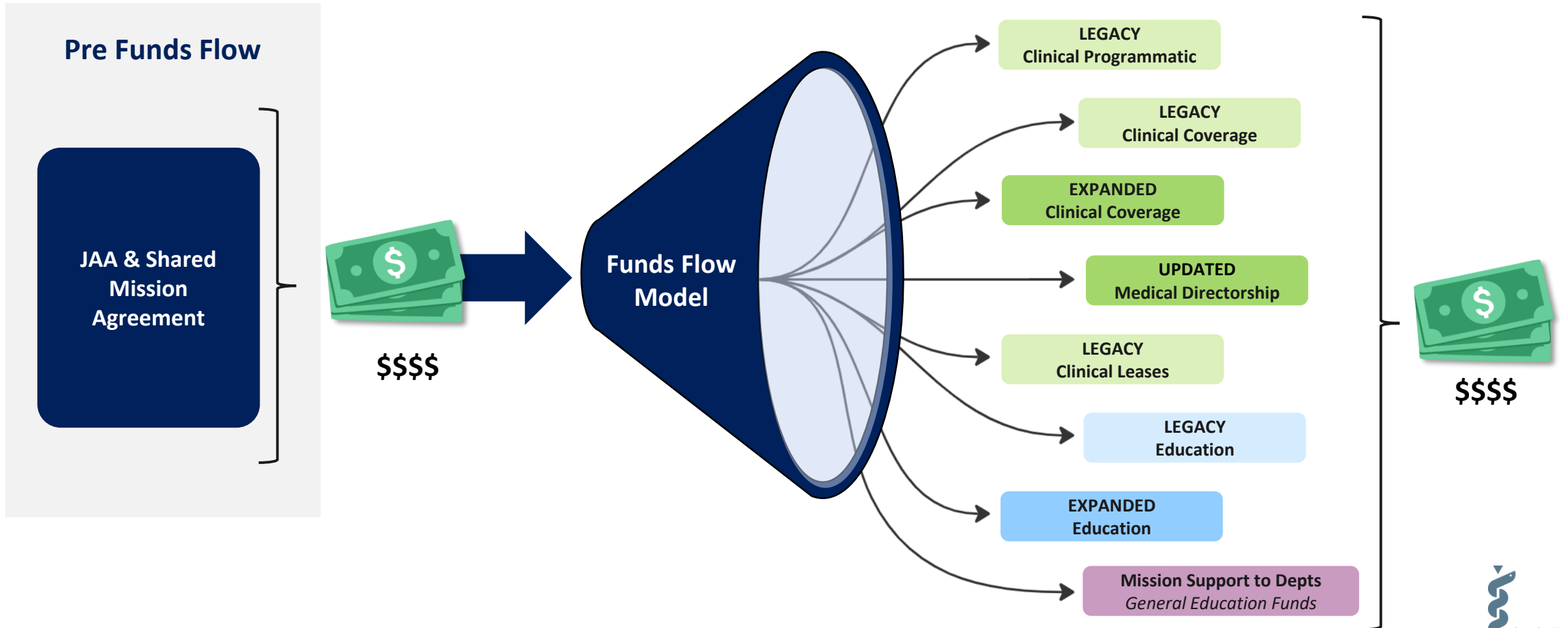
- 2022 – Financial Transformation and Initial Planning and development
- 2023 – Model creation and refinement
- 2024 – Base year for new methodology
- 2025 – First year of full methodology, refinement of compensation plan
- 2026 – Still a work in progress.....

Funds Flow Methodology



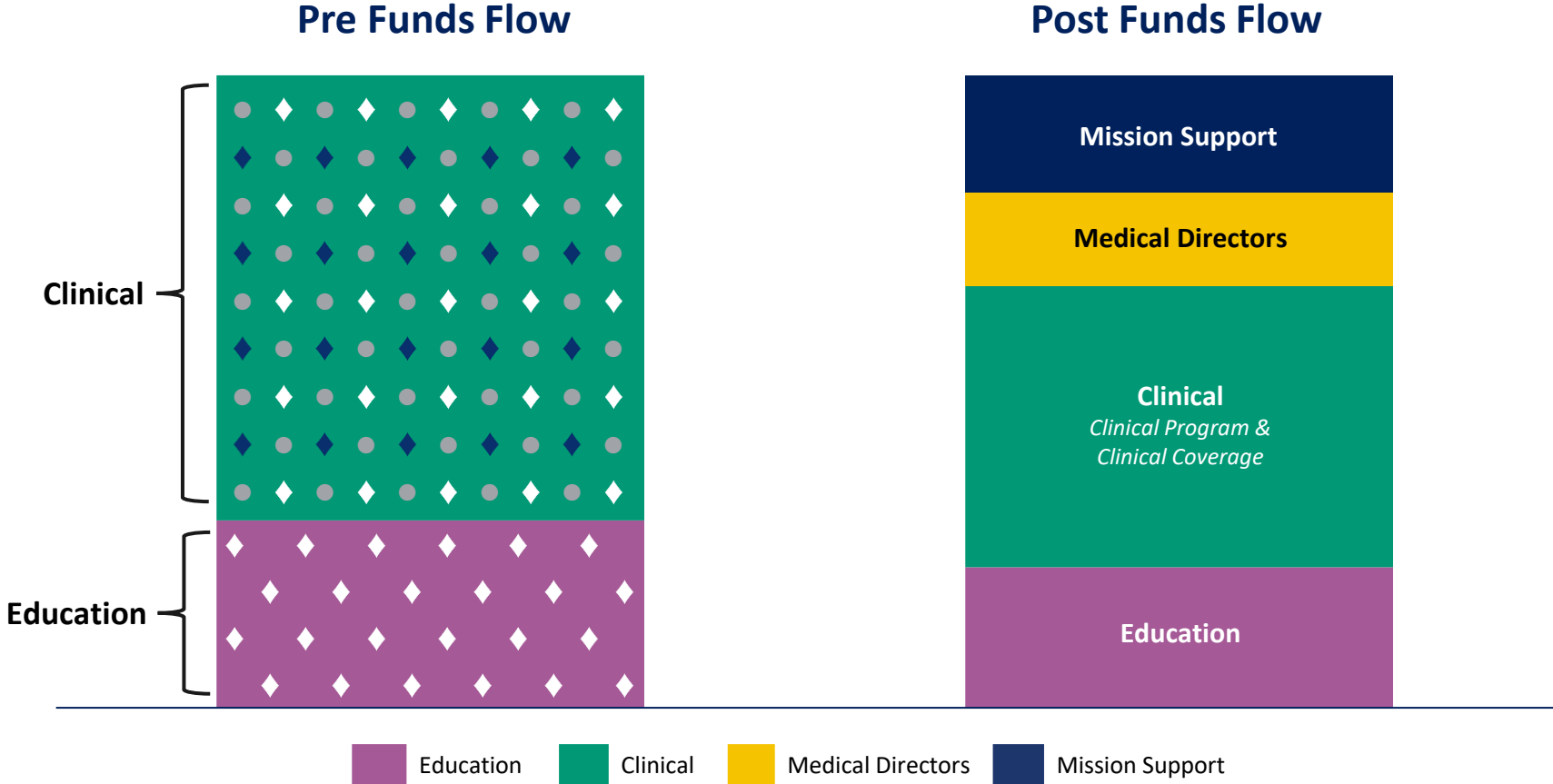
Funds Flow Support JHHS to SOM | Allocation of Revenue

The **same amount of revenue** is going in and coming out of the pool – it's just being **allocated differently**.



JHHS Funds Flow Support | Allocation between Categories

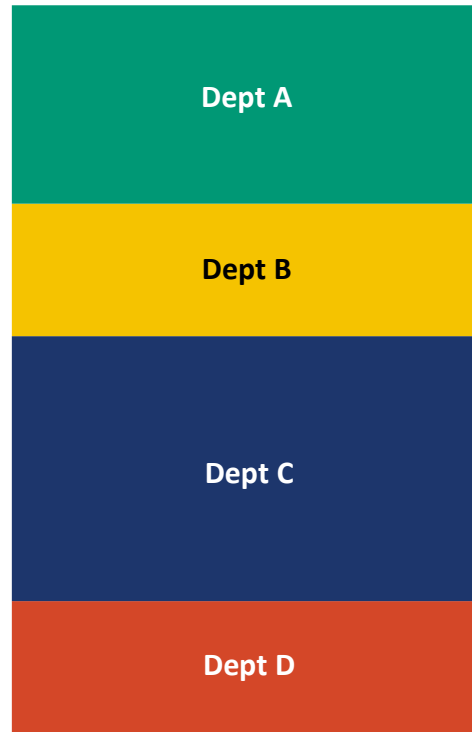
While funding between categories has shifted, the **total amount remains unchanged.**



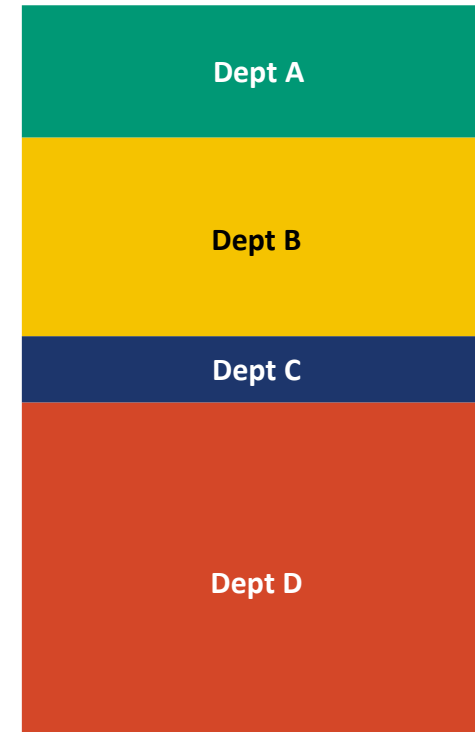
JHHS Funds Flow Support | Allocation by Department

While departmental allocations have shifted, the **total amount remains unchanged**.

Pre Funds Flow



Post Funds Flow



Funds Flow Methodology – JHHS to SOM

Mission	Category	Methodology
<i>Admin</i>	Other JHHS-Supported Academic Positions	For each discrete JHHS-supported non-Medical Director role, support is calculated at individual faculty level: "% FTE required" x "total compensation and fringe".
<i>Clinical</i>	Medical Directorship	For each discrete Medical Director role, support is calculated at individual faculty level: "% FTE required" x "total compensation and fringe".
<i>Clinical</i>	Clinical Coverage	For hospital-based departments (or specific coverage divisions): Clinical coverage will be calculated as the clinical deficit occurring within the clinical P&L at an agreed upon level of faculty expenses based on a mutually agreed upon staffing model and compensation at 40th percentile benchmark.
<i>Clinical</i>	Programmatic Support	For all non-hospital-based departments: Programmatic support is calculated and locked in for three years based on the actual clinical deficit occurring within the clinical P&L contingent on that department producing with a 15-percentile point (pp) gap between compensation and productivity benchmarks.
<i>Education</i>	Discrete Education Roles – GME	For all discretely identified education roles (GME only), funding is calculated at the individual (faculty and/or staff) level based on ACGME guidelines: % FTE required by role X total individual compensation and fringe .
<i>Education</i>	Residents and Fellows	For all residents and ACGME (and like) fellows, funding is calculated at the individual learner level, his/her/their salary and fringe based on the corresponding PGY level, plus a stipend at a rate of \$1,000/year.

Funds Flow Methodology – SOM to Depts

Mission	Category	Methodology
Research	Over-the-Cap	75%* of the sponsored effort on grants X (base salary – NIH cap) plus fringe.
Research	K Award Support	Sponsored effort on K Award grants X (base salary – NIH cap) plus fringe. <i>Note: Base salary is capped at the median salary of K Awardees of \$175K in FY24.</i>
Research	Academic Infrastructure Support	10%* X Modified Total Direct Costs (<i>Total direct costs less certain expense categories such as subcontracts above \$25k, capital equipment, rental space, etc. which are excluded from the cost basis for F&A calculations</i>). <i>Note: MTDC is based on a 3-year average to smooth out any year over year fluctuations.</i>
Education	Discrete Education Roles – UME and OVDE	For all discretely identified education roles (UME and OVDE), funding is calculated at the individual (faculty and/or staff) level as follows: % FTE required by role X total individual compensation and fringe.
Education	General Education Fund	At the department level, general education funding is calculated as following: Average physician compensation and fringe per FTE X number of residents and ACGME (and like) fellows divided by 12*. <i>Note: For departments with Core Clerkships, an additional 1.0 faculty FTE of funding is added. Average physician compensation calculation does not include Clinical Associates or Research Associates.</i>

Challenges

Compensation and Productivity alignment for health system clinical programmatic support

- Departments are expected to produce, on average, at a level 15 percentile point (PP) above their compensation percentile
- Required need to refine department compensation plan, incentives/metrics were misaligned

Mission Support Funding

- Initial funding based upon “what was left over”
- Requires need to create metrics and plan for future funding

Challenges - What we heard...what we did... and what's next

What we heard...

“Be transparent about the calculations”

“Cannot connect the dots”

“Need to see transparency”

“Hospital tells us they are giving the SOM money to be distributed, but we don't know if that's correct, we assume it is, but we don't know the math of that distribution”

“Concerned about the triangulation”

“We cannot see the funds”

“Why am I getting less funds?”

We recognize...

- There are always “winners” and “losers”
- Significant input, communication, presentations, more communication, review, refinement

What we did...

- Conversations and communication (over and over)
- Transparency and input on calculations
- Funds flow education sessions

What's next...

Where we are headed...

- Compensation plan refinement continues
 - Alignment with funds flow methodology
 - Retention of faculty (most faculty were paid less than 40th percentile)
 - Alignment of compensation and productivity 15PP
- Modeling SOM funds flow to department- contingency for eventual loss of federal funding and indirect cost recovery
- Re-communication of plan and re-education
- (Still) Refining the formal Master Services Agreement
 - Growth in costs compared to base year to when plan was developed exceeds available funding
- (Still) Developing the Academic Mission Support funding plan

MU School of Medicine at a Glance



School of Medicine
University of Missouri Health

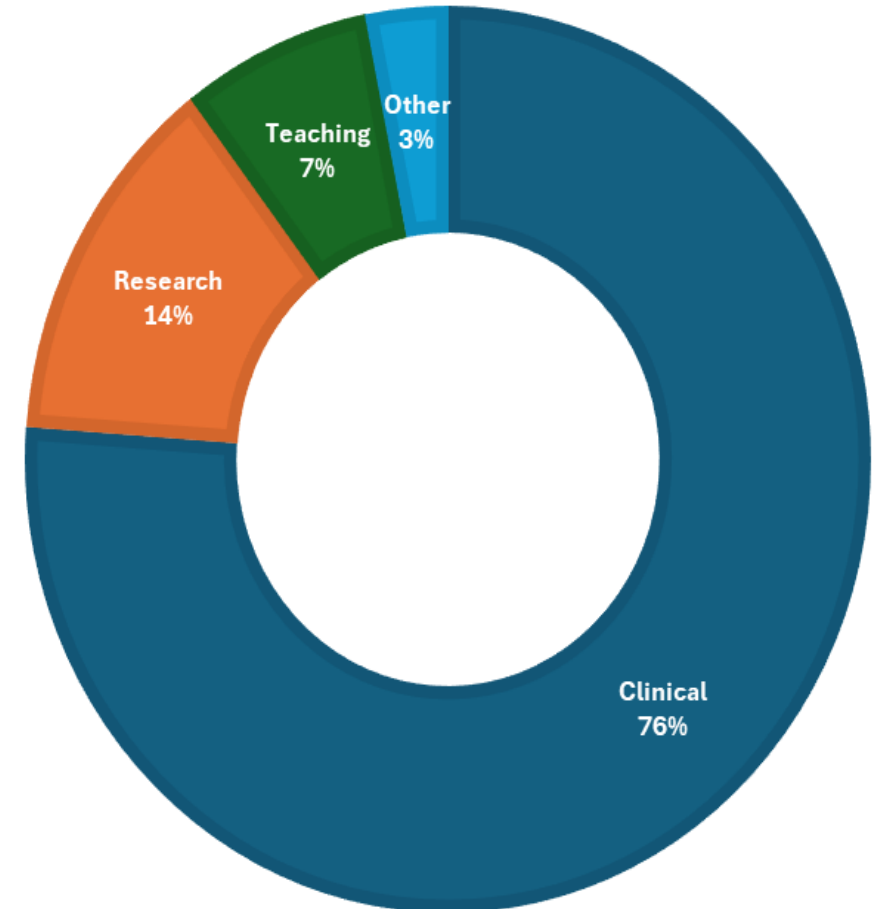
Total Employees: 2,076

Faculty: 742 Staff: 1,334

Total Learners: 1,267

Medical students: 528 Residents and fellows: 466 residents, 117 clinical fellows, 47 postdoctoral fellows

PhD and master's degree students: 57 PhD students, 52 master's degree students





CARTS acronym

Purpose: To financially support aligned missions and goals of MUHC and SOM.



C	A	R	T	S
<p>CLINICAL</p> <p>Fund = 0500 Program Code = C8765</p> <p>Programmatic Support Deficit Support</p> <ul style="list-style-type: none"> * APPs * Departmental * Division * Performance Based 	<p>ADMINISTRATIVE</p> <p>Fund = 0500 Program Code = C8766</p> <p>Chair Support Clinic Admin Support Medical Directorships</p> <ul style="list-style-type: none"> * Departmental * Institutional 	<p>RESEARCH</p> <p>Fund = 0500 Program Code = C9599</p> <p>Academic Mission Support</p>	<p>TEACHING</p> <p>Fund = 0500 Program Code = C8768</p> <p>Chair Oversight Program Directors Coordinator Support Number of Residents</p>	<p>RECRUITMENT & STRATEGIC</p> <p>Fund = 0500 Program Code = C8767 Program Code = C8769</p> <p>Recruitment (Faculty Deficit) Strategic Initiatives</p>



Current Operating Environment

Departments are operating in notably different economic environments

General sense that the Chairs are operating in a zero-sum environment

No clear understanding of organizational finances

Chairs highly value departmental autonomy but acknowledge the broader shift among SOMs and faculty practices toward standardization and group alignment

Views are mixed on enhancing the practice's collective role; however, several noted that coordinated funds flow requests by the Chairs could strengthen the CARTS process.



Challenges in the Legacy CARTS Model

Funding was based on *pitch-driven* processes, not standardized needs.

Lack of transparency created distrust and siloed behavior.

Inconsistent performance expectations across departments.

Clinical growth outpaced CARTS funding growth.

Increasing tension between strategic investments and operational deficits.



How We Approached the Redesign

Our Process and Principles:

Launched multi-phase, **iterative design process** (Dec 2024–Aug 2025).

Core principles:

- Transparency and simplicity
- Align funding with mission and strategic priorities
- Balance incentives across clinical, research, and education missions

Stakeholder-driven: continuous input from Chairs, Dean's Office, MUHC.

Key Design Elements & New Funds Flow Components



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Production-based clinical support: wRVU and cFTE models.

Education support: fixed allocation per trainee.

GME admin funding: based on ACGME guidelines.

Performance incentives: up to 5% tied to operational/quality/financial metrics.

Support for subscale services: strategic supplementation for essential programs. Structured research support: start-up funding + over-the-cap salary support

Structured research support: start-up funding + over-the-cap salary support



New Model CARTS-C component

- 1 **Clinical Payments**
- 2 Faculty Start-Up / New Hires
- 3 Health System Admin Roles
- 4 GME Administration
- 5 Education Support
- 6 Research Support
- 7 Incentive Payments
- 8 Call Coverage
- 9 Support for "Sub-Scale" Programs

The clinical support payment needs to be designed such that it defines the expected necessary clinical income. Typically, these payments have 5 elements:

Clinical Payment Element	Payment Formula / Description
A wRVU-Based Payment	$\frac{\text{Median Comp by specialty}}{\text{Median wRVUs by specialty}} \times \text{Actual wRVUs produced by specialty}$
B cFTE-Based Payment	Agreed upon cFTEs needed for hospital-based coverage areas \times Median Comp by specialty
C Department Admin / Overhead Coverage Payment	Percent (%) of actual professional collections by the department
D Assessments & Other Centralized Expenses*	Expenses that are outside the direct control of the department (e.g., Dean's tax)
E Faculty Benefit Coverage Payment	Actual faculty benefit costs incurred by the department

Challenges & Lessons Learned Along The Way During



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Balancing flexibility with accountability was harder than anticipated.

Defining "structural vs performance" deficits required deeper data.

Managing cultural resistance to standardization needed intentional change management.

Faculty trust increased only when financial modeling was transparent, data-driven, and department-specific.



Key Insights for the Future

What I've Learned About Funding Models

Start with trust and transparency — without it, no model succeeds.

Data beats anecdotes — rigorous modeling builds credibility.

Align dollars to behaviors and outcomes — funding must incentivize mission-critical activities.

Expect evolution — no model is "set it and forget it"; adaptation is continuous.

Funds Flow: Reminder of Objectives and Implications



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What is the proposed model trying to achieve?

- Create consistent operational expectations across all departments
- Hold Chairs accountable for both productivity of the faculty and admin/OH expenses within the Department
- Reduce the administrative burden and inconsistency of the model in place today

What do the modeled FY24 financials tell us about department-level performance?

Departments in surplus **ARE able** to cover all their expenses (e.g., compensation, admin expenses, etc.)

Departments are generating a surplus for three primary reasons:

- Faculty production outpaces compensation relative to benchmark
- Admin/OH expenses are below allowable rate in the model
- Department has some source(s) of income outside the scope of the funds flow model and they make a margin on that income

Departments in deficit **are NOT able** to cover all their expenses and would need to make operational changes to get to breakeven or better performance.

Operational changes could include:

- Improving the ratio of productivity to comp (increase productivity, reduce unfunded time, or reduce comp)
- Reducing department administrative expenses
- Scaling down / eliminating unprofitable endeavors (outside activities or in some cases clinical services where they can't get needed levels of performance)



Concluding Thoughts (1 of 2) Compensation Plan Design

- During the department reviews, several leaders and Chairs shared feedback that the current compensation plans may no longer fully reflect the change in revenue inflows.
- As the funds flow model changes, there appears to be a growing need to ensure compensation structures remain aligned with departmental performance, individual contributions, and the broader clinical enterprise goals.
- We are going to launch a process to review compensation plans to ensure their overall alignment with our enterprise goals and objectives, including appropriately rewarding faculty for individual productivity.



Concluding Thoughts (2 of 2) Implications

- Through this process, we understand we cannot create an unsustainable clinical enterprise or unsustainable faculty practice. We are committed to maintaining and enhancing the role of the Chair and preserving the foundational principles under the Collected Rules.
- We are not different from other AMC's facing a tough financial position driven both by policy (e.g., Medicaid Directed Payment programs, OBBBA) and by variances from budgeted performance and the reimbursement environment.
- Now more than ever, we need an aligned economic model based on consistent standards and expectations that will better help us drive performance collectively.

Funds Flow Governance



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Funds Flow Governance Committee

Membership:

FF Process Lead

MUHC Finance

SOM Finance

UP Leadership

Hospital CMO

SOM Vice Dean

3 – 4 Rotating Department Chairs

- Medical Surgical
- Hospital-Based
- At large



The Funds Flow Governance Committee is charged with

1. Leading the annual process to review and recommend changes to universal funding algorithm reflecting broader clinical enterprise budget targets, affordability requirements, etc.
2. Adjudicating annual department-specific funding requests outside formulaic funding approach, such as:
 - Review and recommend for approval service-specific coverage models and associated work expectations / service agreements based on recommendation of CMO and Department Chair
 - Establish and/or re-base annual funding support for sub-scale programs based on recommendation of MUHC Finance, CMO and department Chair
 - Incorporate expected, budgeted locums usage into annual funding agreements based on recommendation of CMO and Department Chair
 - Evaluate and vet any other exception proposals as submitted by departments
3. Overseeing pro forma process and determining ramp-up support for new faculty based on recommendation of strategy and ramp up budget set by MUHC Finance

Considerations:

- *The FF Governance Committee recommends updates to the Funds Flow model and the EVCHA/Dean and CEO approve*
- *Universal refinements and updates to the Funds Flow model should be shared transparently to all Chairs*
- *Annual review process should line up with existing budget timelines*

Thanks for your time today!
Questions & Answers