Mississippi GME- Cap Strategies, Rate Setting, and Other GME Considerations

May 7, 2021

PKFHealth, LLC

Today's Agenda

- External GME Environment
- Cap Setting Strategies
- Rate Setting Process and Importance of Cash Flow
- Rural Training Tracks & Teaching Health Centers
- Q&A

GME is in a transformative stage, with a number of factors both in and outside of our control.

Recent COVID Relief measures, workforce needs and payment reform.

ACGME conversion and costs to support GME.

Importance of cap creation and strategies to mitigate risk and optimize allowable reimbursement.

Payment reform has been discussed while the pipeline into GME has been growing, creating a funding bottleneck.

Table 2. **MD and DO Enrollment Growth Since 2002**

	2002	2018 and 2019		
	Enrollment	Enrollment	Increase	% Increase
MD (2019)	16,488	21,869	5,381	33%
DO (2018)	3,079	8,124	5,045	164%
Total	19,567	29,993	10,426	53%

Source: September 2020, AAMC Medical School Enrollment Survey: 2019 Results.

Though there is acknowledgment of physician shortages, especially in primary care, there are limited ways to increase caps or create incremental reimbursement to support GME.

How has the growth in medical schools and single accreditation impacted GME? There is a lot of pressure!

Pressure on New Teaching Hospitals

- Because new programs can be established and incremental cap slots be generated, there has been a lot of outreach and partnerships between medical schools and these hospitals.
  - Need to understand the mission, tangibles and intangibles.
  - Make vs. buy strategy.

Pressure to Think Creatively About Funding

- RTTs, FQHCs, THC, Medicare GME Affiliation Agreements, bed counts, program mergers, closed hospital slots, CAH, etc.
- Rural vs. urban and practicality.

Pressure to Consider Collaboration, Especially if Small/Rural

- Consortiums and academic affiliations.
- Also other learners and overall education strategy.

GME Cap Setting

There are three distinct phases of GME programmatic development and implementation, with cap establishment key to future reimbursement.

Significant investment, usually no offsetting GME reimbursement.

5 year cap build-up, with establishment of per resident amounts (PRA).

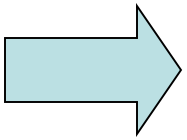
Goal to optimize caps and reimbursement, manage costs, and mitigate risks.

Some states and philanthropic organizations provide start-up support because it is not explicitly reimbursed by Medicare. HRSA grant support has been crucial to reducing economic barriers to GME pursuit for RTTs.

Where residents are deployed will have a direct impact on cap amounts and future funding.

Operational

- Where will residents be deployed?
- How will we accommodate clinic rotations?
- Who will oversee and train the residents?



- The Review Committees for the ACGME determine the baseline requirements for resident experiences.
- Each program pursued has its own clinical and educational requirements, which dictate where the residents need to train, and how much teaching and supervision would be required by program leadership, core faculty and other physicians..
- Continuity of care requirements can be achieved in several ways:
  - Hospital clinics, community-based sites, FQHCs, etc.

In general, hospitals are paid for the number of accredited positions it has and are limited or capped at how many residents it may get reimbursed for by Medicare based on a specific methodology.

An example of the cap calculation, and its potential implications for future funding, is as follows:

Family Practice	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
PGY 1	4	4	4	4	4	4	4
PGY 2		4	4	4	4	4	4
PGY 3			3	3	3	3	3
Claimed FTEs	4	8	11	11	11	11	11
Non-Claimable FTEs	-	1	1	1	1	1	1

Initial Cap = 4 * 3 = 12
Reduction = (6/73) * 12 = 1.00

Cap = 11 versus 12

- **Current regulations allow for a five year build-up, with non-claimable rotations (such as those to other hospitals) proportionally reduced from the final cap calculation.**
- **During this period (at any time prior to the end of the 5th year) additional programs can be started and contribute towards the caps (rural vs. urban).**
- **Once set, the caps can be used for any type of approved program.**

Urban hospitals have a five year window to establish its caps; rural hospitals can incrementally add new programs and caps.

July thorugh June										
Start-up	Start-up	Start-up	Year 1	Year 2	Year 2	Year 4	Year 5	Year 6	Year 7	Year 8
20-21	21-22	22-23	23-24	24-25	25-26	26-27	27-28	28-29	29-30	30-31
Program Planning			First Residents				Critical Cap Year	*Caps Set*		

Because accreditation process can be lengthy, new program planning for multiple programs needs to be started as early as possible.

Accreditation by Fall crucial for recruitment for any other program(s).

Have one PGY class filled.

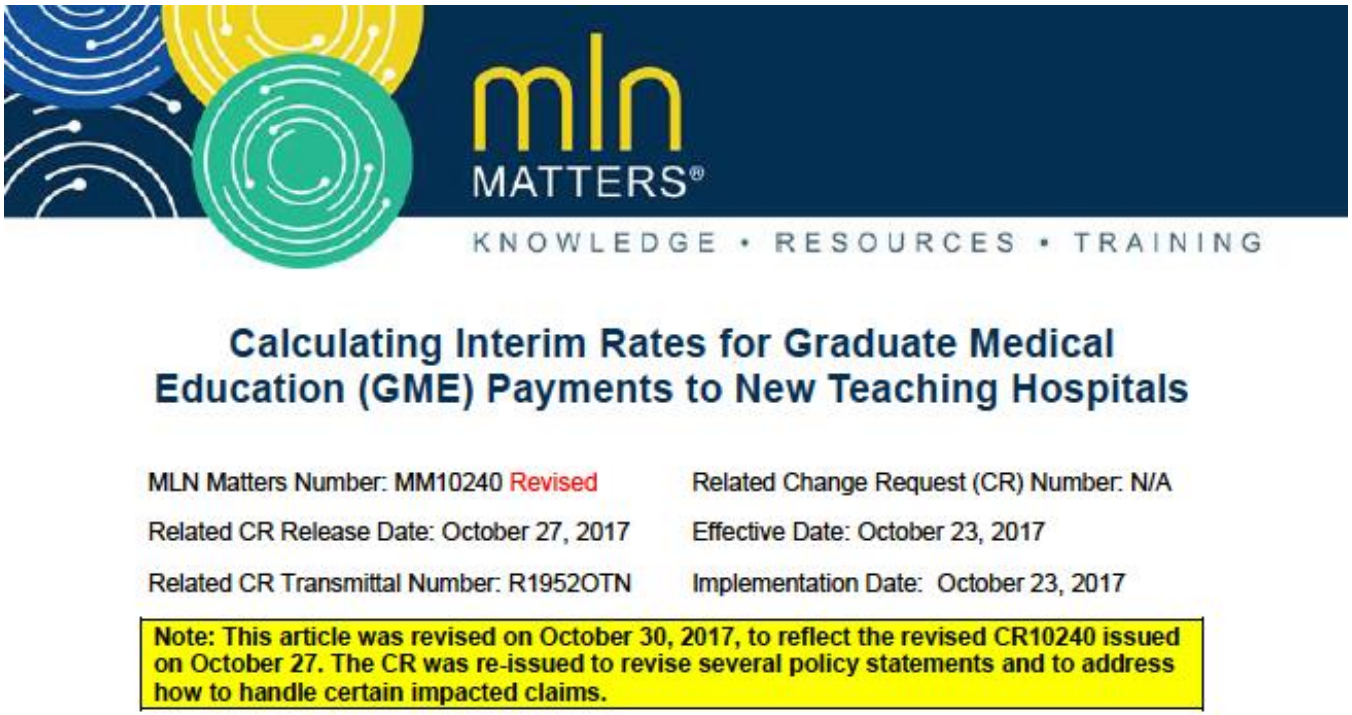
Once caps are set they are in aggregate, not program specific. Rolling averages and other reimbursement impacts start.

Some cap nuances:

- Cap limits are recorded, and rolling averages are calculated, in the first full cost reporting period after the fifth year.
  - Programs that start later in the five-year window and not at full complement will result in a lag in reimbursement.
- Caps can be shared through a Medicare GME Affiliation Agreement, allowing for strategic flexibility.
  - “One for many”
  - Geographic, program and ownership thresholds
  - New teaching to new teaching now allowed, and to legacy after 5 years
- CAHs can be considered a non-hospital site, adding to caps.
- Section 5506 process- closed hospital cap allocation, based on demonstrated likelihood of using the slots and ranking criteria.
- COVID Relief measure to add 1,000 new slots over five years, through application process.
- RTTs can provide a cap bump up for participating urban hospital.

Rate Setting Process

For new teaching hospitals, there is a process to facilitate concurrent payments to offset GME costs.



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Calculating Interim Rates for Graduate Medical Education (GME) Payments to New Teaching Hospitals

MLN Matters Number: MM10240 Revised

Related Change Request (CR) Number: N/A

Related CR Release Date: October 27, 2017

Effective Date: October 23, 2017

Related CR Transmittal Number: R1952OTN

Implementation Date: October 23, 2017

Note: This article was revised on October 30, 2017, to reflect the revised CR10240 issued on October 27. The CR was re-issued to revise several policy statements and to address how to handle certain impacted claims.

Hospitals do not (and should not) have to wait for a cost report to be settled or audited to start to receive allowable DGME and IME reimbursement.

DGME rate setting may come through interim payments or an initial lump sum, while IME is processed separately.

DGME Payments

- Based on an temporary average per resident amount (PRA)- latest Census Region PRA.
- Actual PRA for hospital to be set based on first full cost reporting period.

IME Payments

- Payments processed by MAC based on a preliminary ratio of interns and residents to beds.
- PS&R will add an IME amount to each processed Medicare FFS and Managed Care claim.

Hospitals do not (and should not) have to wait for a cost report to be settled or audited to start to receive allowable DGME and IME reimbursement. Also, make sure your MMC bills are coded to note you are a teaching hospital.

What are the documents you need to substantiate the rate request?

- Proof of accreditation (e.g., ACGME letter).
- Number of accredited slots being trained during the relevant cost reporting period.
  - For example, for an 8/8/8 program, the ACGME letter would be for 24 slots, but in the first year the request is for at most 8 FTEs (less if the cost reporting year does not end on 6/30).
  - We often add copies of the PGY contracts.
- Block or rotation schedule, with an estimate of allowable FTEs to be claimed.
  - Need to reduce estimate based on Medicare counting rules.
- Available bed count and Medicare utilization from most recently submitted cost report.

We usually transmit this request to the MAC months before residency training begins, allowing for questions to be answered and to initial the process for rate setting as each new class begins.

Actual PRA will be based on the lower of the hospital's actual costs or that of comparative pool from MSA or Census region.

Non-Billable Faculty Time

- Protected, non-billable time varies by program for:
  - Program director
  - Core faculty
  - Other faculty, such as community-based

Resident Costs

- Resident salary and Benefits.
- Driven by FMV not Medicare.
- Will be a standardized amount.

Other Costs

- Dedicated coordinator costs.
- Clinic costs.
- Research costs.
- Didactics and other educational modules.
- Step-down allocations.

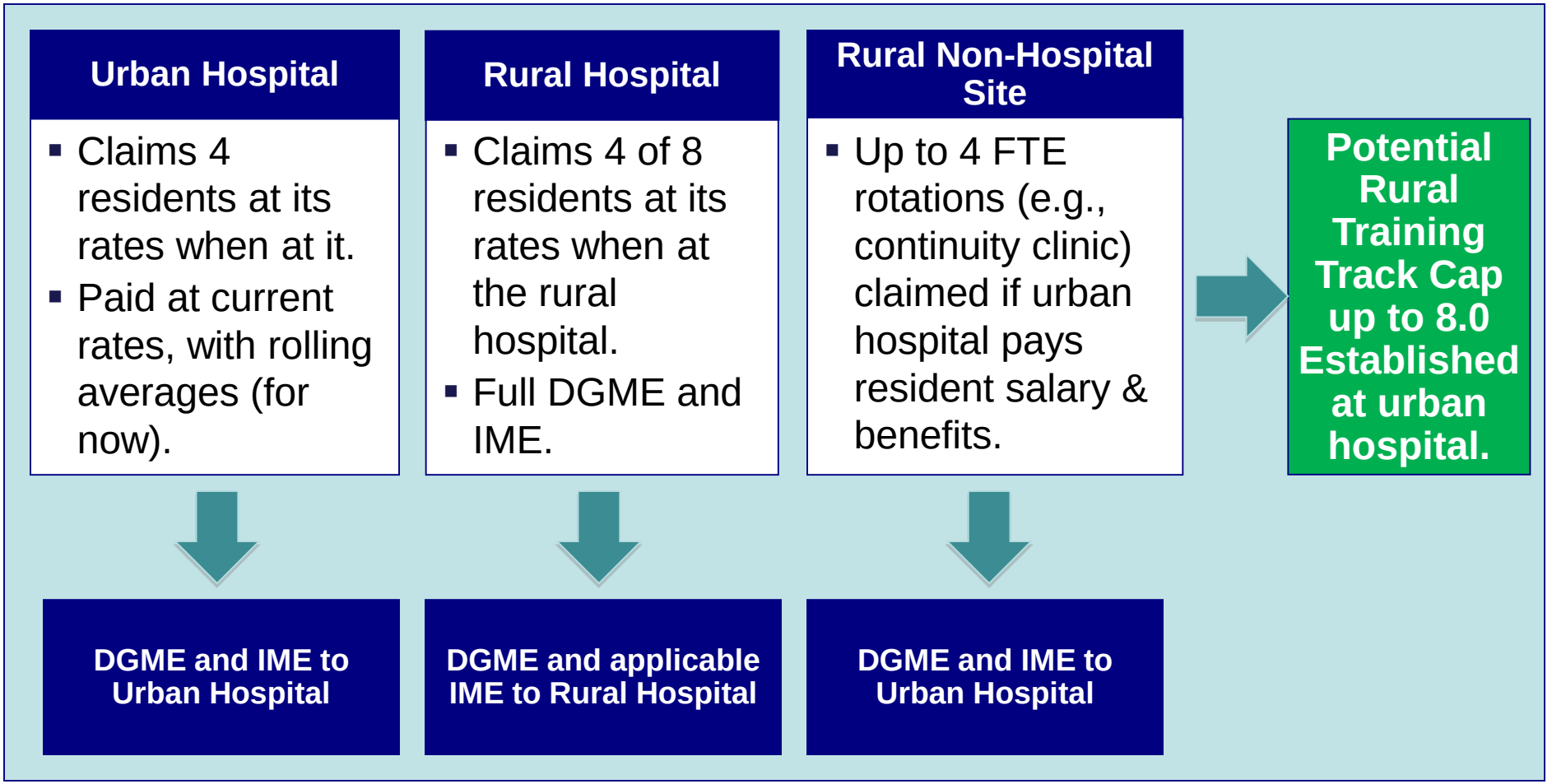
Medicare requires hospitals to substantiate its costs in order to obtain allowable reimbursement. ACGME standards do not coincide with CMS requirements, which can result in conflicting interpretations of rules and regulations. Most of these costs will be the basis for the PRA calculation.

Rural Training Tracks

Rural training tracks can provide programmatic flexibility and depending on how structured, Medicare reimbursement benefits.

- **Rural Training Track Programs ("RTT")**
  - RTT programs provide an opportunity for urban and rural hospitals to partner and promote rural training.
  - New RTT programs can allow urban hospitals to obtain enhanced reimbursement, and for rural hospitals to establish residency training and to qualify for Medicare GME funding.
  - Family medicine programs tend to be established as "1-2", with the first year at the urban site and the next two years at the rural site.
  - For allowable reimbursement, RTT programs can be established for any program that trains >50% of residents in a rural setting.
  - For Medicare reimbursement CMS rules focus on location of training, whether the program is new, and how much time is spent in the rural setting.
  - ACGME is addressing how to better accommodate and recognize rural training through the accreditation process.

The following illustrates how the funding could flow to an urban hospital should it participate in a new RTT with 12 residents:



Teaching Health Centers

Teaching health centers are funded through HRSA (not CMS), and are community based GME programs.

- The Teaching Health Center GME ("THCGME") program was established in 2011, training residents in seven specialties: FM, IM, pediatrics, IM-peds, geriatrics, Ob-gyn and psychiatry, plus dentistry and pediatric dentistry.
  - New or expanded training programs

- Can be located in FQHCs, community mental health centers, RHCs, Indian Health Service sites, or other outpatient clinics which operate a primary care residency training program.

- Funding uncertainty is a significant issue for THCGME programs, with continued funding predicated on Congressional action.
  - New THCs and continuation awards were effective 7/1/20

We are currently working with George Washington University on a costing study to provide HRSA with a PRA.

Questions and Answers

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