Office of Mississippi Physician Workforce -
Rural and Community Based GME Program Opportunities
October 7, 2022

PKFHealth, LLC

Today's Agenda

- GME reimbursement and funding overview
- Potential paths and rural and community-based training opportunities
- Types of hospitals and how reimbursed
- Section 127 of CAA
- Teaching Health Center grant opportunities
- Q&A

The majority of GME funding comes from Medicare, but there are other sources used to subsidize residency training.

Direct Medical Education (DGME)

Direct costs of training, based on a per resident amount (PRA)

+

Indirect Medical Education (IME)

Add-on payment to offset inefficiencies

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Additional Support for GME

- **Medical Schools**
- **Faculty PPs**
- **Medicaid FFS**
- **Children's GME**
- **VA/DOD**
- **HRSA-THC/RTP**
- **Philanthropy**

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Total Reimbursement for GME

Hospitals are limited (or capped) at the number of Medicare funded DGME and IME FTEs. Rural hospitals have favorable cap rules.

There are several ways GME can be developed and grow in rural and underserved areas.

Rural Hospitals

- Can add to caps any time for new programs (not limited to one five-year period).
- Rural reclassification and IME increase.
- Need to consider type of hospital.

Rural Training Programs

- Urban hospital/partner can add to caps if >50% of time spent in rural area.
- HRSA has been awarding development grants to support planning ($750,000).

Teaching Health Center Program

- Funded by HRSA, not Medicare, at $160,000 per resident.
- Eligible entities are community based (e.g., FQHC), not a hospital or medical school.

Any of these options require careful planning, an investment in residency training for the short and long-term, and the likely need to collaborate and partner with other sites with a clear governance structure in place.

The type of hospital can have a significant impact on the amount of allowable GME reimbursement that may be received.

	How Are Hospitals Reimbursed by Medicare?		
Type of Hospital	**DGME**	**IME**	**Notes**
IPPS Urban	Yes	Yes	If GME naïve, under caps, or qualifying as an RTP partner and >50% training in a rural area.
IPPS Rural	Yes	Yes	Can grow GME caps for new programs or establish a RTP.
Sole Community Hospital	Yes	Yes*	Does not qualify for full IME if receiving higher, hospital specific payment. HMO business fully reimbursed.
Medicare Dependent Hospital	Yes	Yes*	Qualifies for partial IME if receiving higher, hospital specific payment. HMO business fully reimbursed.
IPPS Rural Reclassification	No*	Yes	No DGME if not an RTP and over caps, otherwise yes. Considered rural for IME only.

Other/Non Hospital	**DGME**	**IME**	**Notes**
Critical Access Hospital	No	No	Cost-based GME reimbursement (not IPPS), or can be treated as non-hospital site for GME training.
Teaching Health Center	No	No	HRSA funded at $160,000 per resident based in part on consideration of direct and indirect costs.

Section 127 of the Consolidated Appropriations Act- Rural Track Programs

New CMS Definition and Opportunities

A "rural track program" is a program, whether separately accredited or not, where residents spend time in both urban and rural settings and the time spent training in a rural place is >50% of the total training for time for residents in the program (or track) as a whole.

- **New opportunity to create "not separately accredited" programs in multiple specialties.**
- **New opportunity for urban hospitals to expand already established and separately accredited rural training programs (RTP) to additional rural sites; a rural hospital can also expand with another RTP of an urban program. No rolling averages in first five years of cap building.**

Visit ACGME at *https://www.acgme.org/what-we-do/accreditation/medically-underserved-areas-and-populations/* for ACGME definition.

Teaching Health Center Updates

HRSA Funded Community Based GME

Opportunities through HRSA for new and expanded teaching health center (THC) grants, as well as THC planning grants.

- **Definition**: ***THCs are community-based residency programs in family medicine, internal medicine, pediatrics, med-peds, psychiatry, ob/gyn, general dentistry, pediatric dentistry, or geriatrics.***
- **Goal**: ***to expand primary care physician workforce in rural and underserved communities.***
- **Funding**: ***$160,000 per resident FTE per year.***

Visit https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education for more information and upcoming notices of funding opportunities.

Each step in the road to establishing THC GME has some element of financing that needs to be considered to sustain residency training.

Program Planning Phase

Sponsoring Institution

- Consortium
- Individual hospital or THC
- Medical School

Governance, DIO and GMEC

Accrediting Body Requirements

- Adequate space
- Scholarly activities and didactics
- Clinical learning and working environment

Call rooms, lockers, clinic space

Programs Pursued

- Curriculum requirements
- Faculty protected time
- Resident minimums
- Continuity of care and clinics

Hospital and other partnerships

Residency Training and Operations Phase

Residency Deployments

- THC/FQHCs
- Hospitals
- Community based sites
- VA and others

Reimbursement and expenses

Hospital Role

- Can new THC program trigger caps/PRA?
- Type of hospital
- Benefits of relationship with THC

Potential payments to/from hospital(s)

Sustainability

- Is $160k adequate?
- How long will funding last?
- What is the rationale for having residents?

How do we manage and support GME long-term?

Hospitals have always and continue to have the deepest pockets to support GME, but that does not mean they "make money" on residency training.

THC HRSA Funding

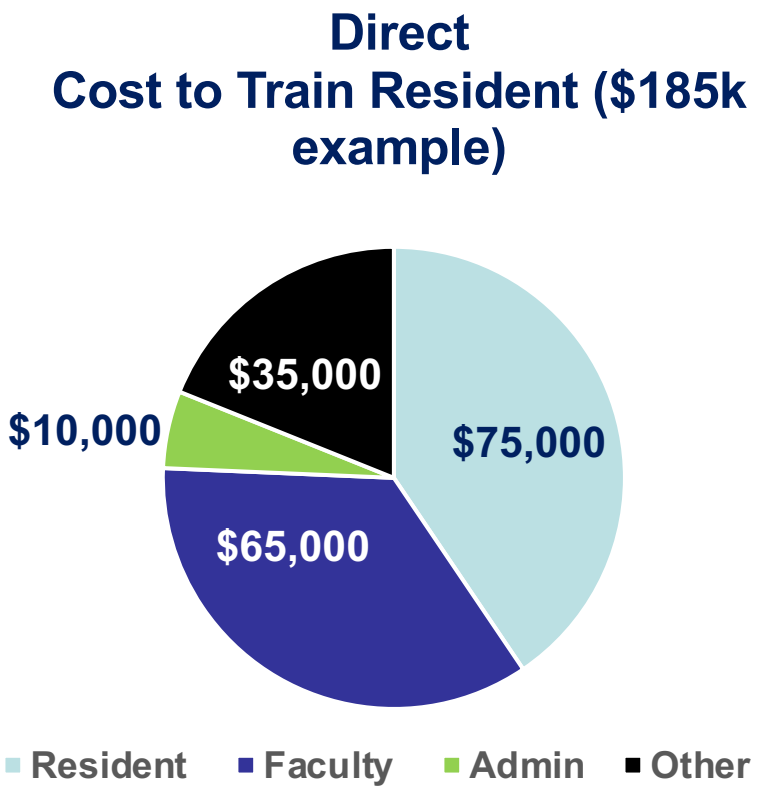
- Now at $160,000 per slot
- Intended to cover resident costs
- Not based on Medicare utilization
- Does not cover all specialties and subspecialties
- Funding is uncertain long-term

CMS Hospital Reimbursement

- Tied to Medicare utilization
- If applicable, Medicaid GME dollars go to hospitals
- Hospital reimbursement varies widely
- Type of hospital can have a significant impact on how allowable reimbursement is generated

Rotations into hospitals of THC residents may result in just CMS reimbursement, limiting the amount of funding to the THC or requiring a negotiation of payment.

How will the $160,000 be spent, and is it enough?



How do we make this work?

- NPSR
- Partnerships with hospitals
- How sponsoring institution is established
- Retention of residents
- Cost avoidance
- Community benefits
- Philanthropy
- State-specific funding
- Foundation support
- Other grants
- In-kind support

This is the basis for sustainability

No matter the path to becoming a Sponsoring Institution, the THC will need some level of support from other partners and participatory sites.

Sponsoring Institution (SI)

THC as SI

- Governance and control directly aligned with THC
- Need to consider administrative costs of oversight
- May limit ability to partner with participatory sites

Consortium Model

- Shared risk among members
- Alignment of program goals
- Potential access to resources that can be offered at a discount or provided in kind

To establish itself as an eligible entity, a THC needs to become its own SI or create a consortium. The THC must demonstrate control over the financing and operations of the program(s). This is not an option for hospital cap relief.

From a recent NOFO for THC funding: "The applicant MUST provide documentation that the residency program is accredited…"

Is there a plan B to support GME if THC funding is not awarded?

Narrative Section	Review Criteria
Purpose and Need	(1) Purpose and Need
Response to Program Purpose: (a) Work Plan (b) Methodology/Approach (c) Resolution of Challenges	(2) Response to Program Purpose (a) Work Plan (b) Methodology/Approach (c) Resolution of Challenges
Impact: (a) Evaluation and Technical Support Capacity (b) Project Sustainability	(3) Impact: (a) Evaluation and Technical Support Capacity (b) Project Sustainability
Organizational Information, Resources and Capabilities	(4) Organizational Information, Resources and Capabilities
Resident FTE Request Justification Narrative (below)	(5) Support Requested

Summary and concluding thoughts:

- The need for physicians in rural and underserved areas is significant, and there are new ways to meet that need through GME.
- The type of hospital(s) that participate in GME can result in a wide variation in amount of allowable reimbursement received.
- Each aspect of the development of new or expanded residency training has some type of economic impact.
- THC funding (both planning and operations) can be a way to deliver GME and physicians at a community-based level, but the funding stream and path to becoming a THC may be more complicated.

Questions and Answers

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