GRADUATE MEDICAL EDUCATION SUMMIT

Program Funding

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Rural Funding – David Evans, MD

State Funding – Ted Epperly, MD

Teaching Health Center Funding – Russell Maier, MD

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Rural GME Funding

Disclaimer

- RRPD-TAC is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement #UK6RH32513.

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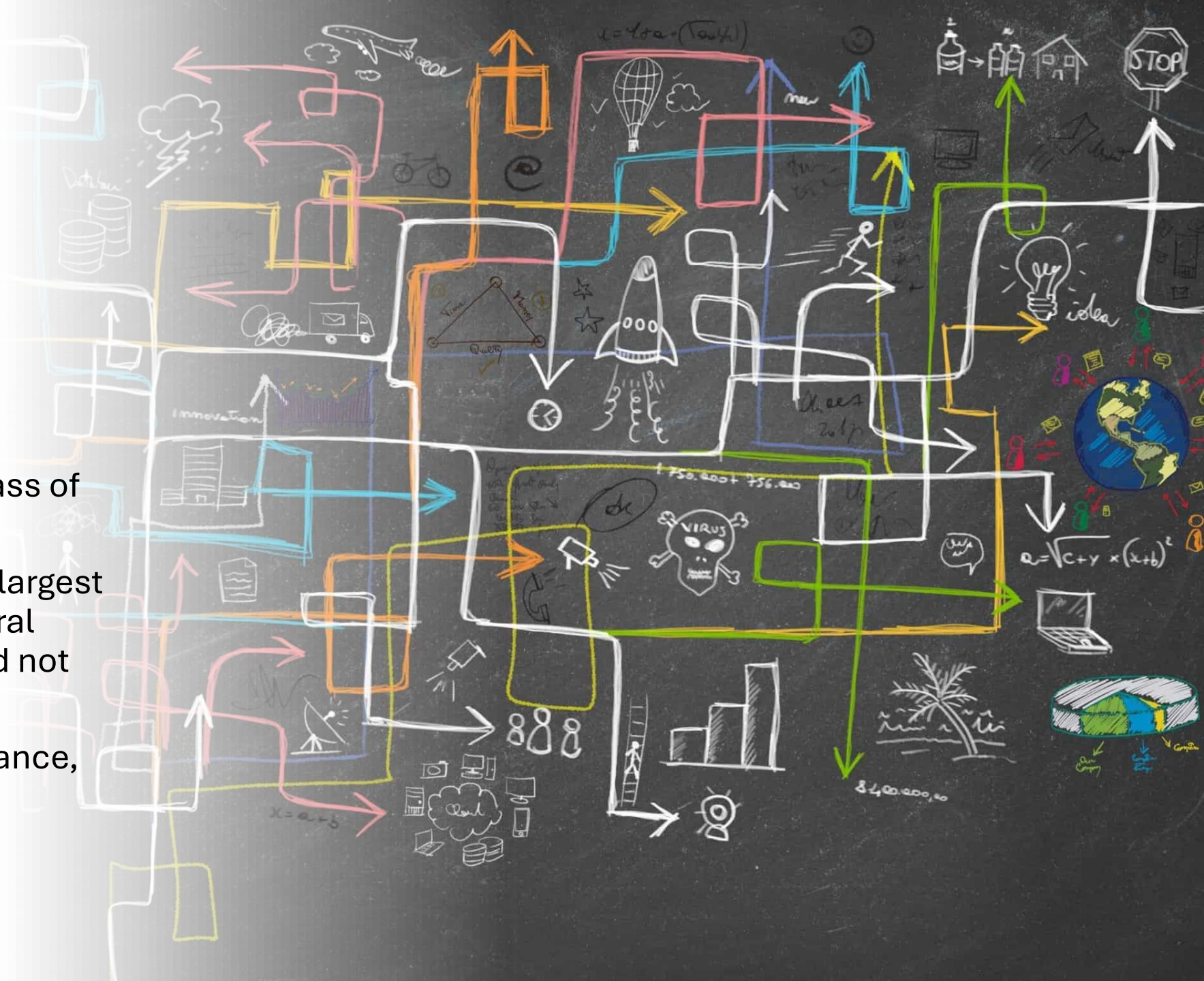
Objectives

By the end of this session, participants will be able to:

- Outline basics of rural GME funding
- Recognize unique aspects of rural GME funding
- Understand the rural residency track program
- Contrast a variety of funding options

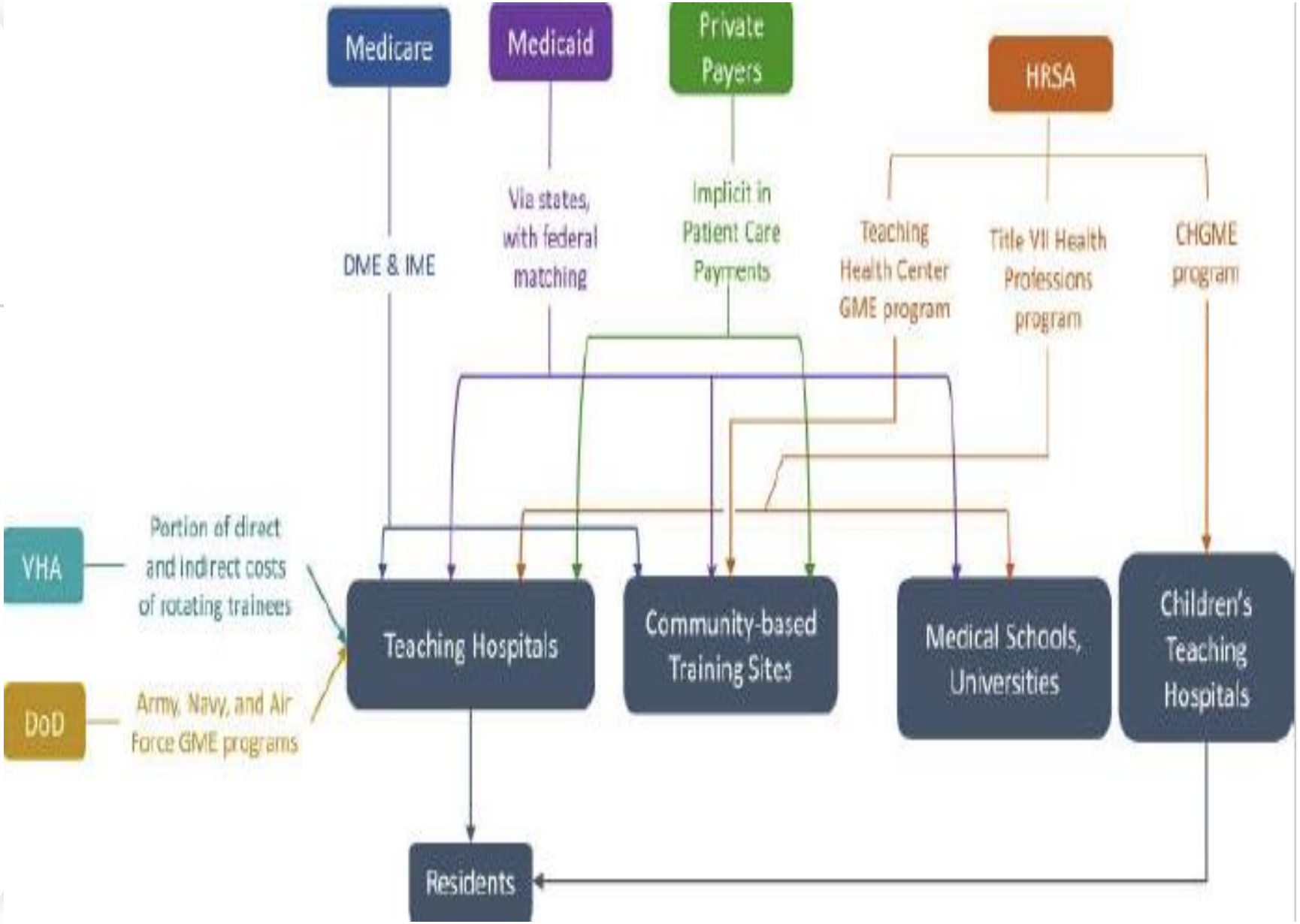
Rural GME funding

- Complexity **beyond** traditional GME funding
- Characterized by a morass of special exceptions
- Medicare funding is the largest source of revenue for rural residencies but it should not be the only one
- Just like in individual finance, diversification is key



Rural GME funding

- Complexity **beyond** traditional GME funding
- Characterized by a morass of special exceptions
- Medicare funding is the largest source of revenue for RTPs, it should not be the only one
- Just like in individual finance, diversification is key



Resources

- RuralGME.org – free with sign in. Tons of tools!
- THCGME.org – also has a toolbox
- AAMC Rural Track Programs: A guide to the Updated Medicare Requirements – free download from AAMC
- RTT Collaborative – Now called Rural Medical Training Collaborative (RMTC)
- VA Mission Act –
- Consolidated Appropriation Act 2021-2022

Rural GME funding sources

- CMS funding – varies according to hospital type
  - Direct GME – pays for Medicare's portion of residency and residents
  - Indirect GME – pays for inefficiency of trainees and is an add on to DRG payments
- Medicaid GME – varies state to state
- Teaching Health Center funding – HRSA
- VA – new Mission Act
- IHS

Rural GME funding sources

- Patient care revenues – how you structure your program plays a huge role here
- Philanthropy – foundations, business

The RTP Model

- Rural/urban partnership
  - Urban/urban hospital
  - rural hospitals and non-hospitals sites
- New rules create more flexibility
  - Accreditation or expansion
  - More specialties
- Greater than 50% of resident training occurs in a rural area
  - CMS defines rural as non-metro Core Based Statistical Area (CBSA)
  - Am I rural? To find out classification
- Both rural and urban hospitals can increase DGME and IME caps

Columbia Valley Community Health – Chelan WA

The RTP Model

- Critical Access Hospitals
  - CAH are not IPPS hospitals
  - CAH do not get DGME or IME – instead claim residency expenses on their cost report and are then paid Medicare's share. This is often less than traditional DGME and IME
  - Urban IPPS hospitals can claim DME and IME for resident time in CAH IF it pays the resident salary and benefits

SEARHC Mt. Edgecumbe Hospital, Sitka AK

The RTP Model

- Sole Community Hospitals
  - Special type of IPPS hospital
  - Rather than DRG payments, SCHs get paid the larger of federal IPPS rates OR a hospital specific rate (based on cost report)
  - If paid the IPPS rate then can get both DGME and IME
  - If paid hospital spec rate then can get DGME but only Medicare Advantage IME
  - Hospital spec usually higher so generally IME only for Medicare Advantage

Central Peninsula General Hospital, Soldotna AK

A Word about Hospital Classification

Geographically urban hospitals can reclassify as rural referral centers

Multiple financial reasons for a hospital to do this

Can act as urban partner for an RTP. To get both DME and IME the RTP must be separately accredited.

Can act as a rural partner for an urban hospital in an RTP

- Reclassification only applies to IME payment

Mat-Su Regional Medical Center, Palmer AK

An Urban/Rural hospital

A Word about Hospital Classification

Geographic location and classification has diverged over the last several years

Rule of thumb

- DGME follows geography
- IME follows classification

There are MANY variations on this theme, each with its own financial implication

Medicaid GME match

- State dependent
- Federal matching money for what sate pays in Medicaid
- Payments often go to hospitals
- Medicaid expansion has opened doors in some states

AAMC publication

VA Pilot Program on Graduate Medical Education and Residency (PPGMER)

- The VA MISSION Act, passed in 2018, addresses several aspects of healthcare for veterans, including GME
- Expands opportunities for medical residents to train in VA facilities
- Address physician shortages and improve veteran healthcare access
- Increases the number of residency positions in VA hospitals and allows for greater flexibility VA GME funding
- The RFP will be issued to VA health centers, and only VA health centers may respond to the RFP on behalf of the non-VA partnering site
- Final rule expected this summer

Veterans Health Administration

Other Funding Sources

- State Funding
- THC HRSA grants
- Clinical income
- Philanthropy
  - Community foundations
  - Business contributions
- Sponsoring Institution/Healthcare system

Rural GME Funding

Key points

- Rural GME funding is complex
- Use available resources
- Keep funding streams diversified
- Ask for help from our WWAMI experts

Yukon-Kuskokwim Delta Regional Hospital

GME Funding – What Can Your State Potentially Do?

Ted Epperly, MD

President, CEO, & DIO | Full Circle Health | Boise, Idaho

GME Coordinator | State Board of Education

Why Is This Important

- **Low Rankings (Physicians/ Capita, GME / Capita)**
- **Innovative / Creative**
- **Size – Not too Big – We Can work Together**
- **Federal Government Not Going to Solve This Problem.**

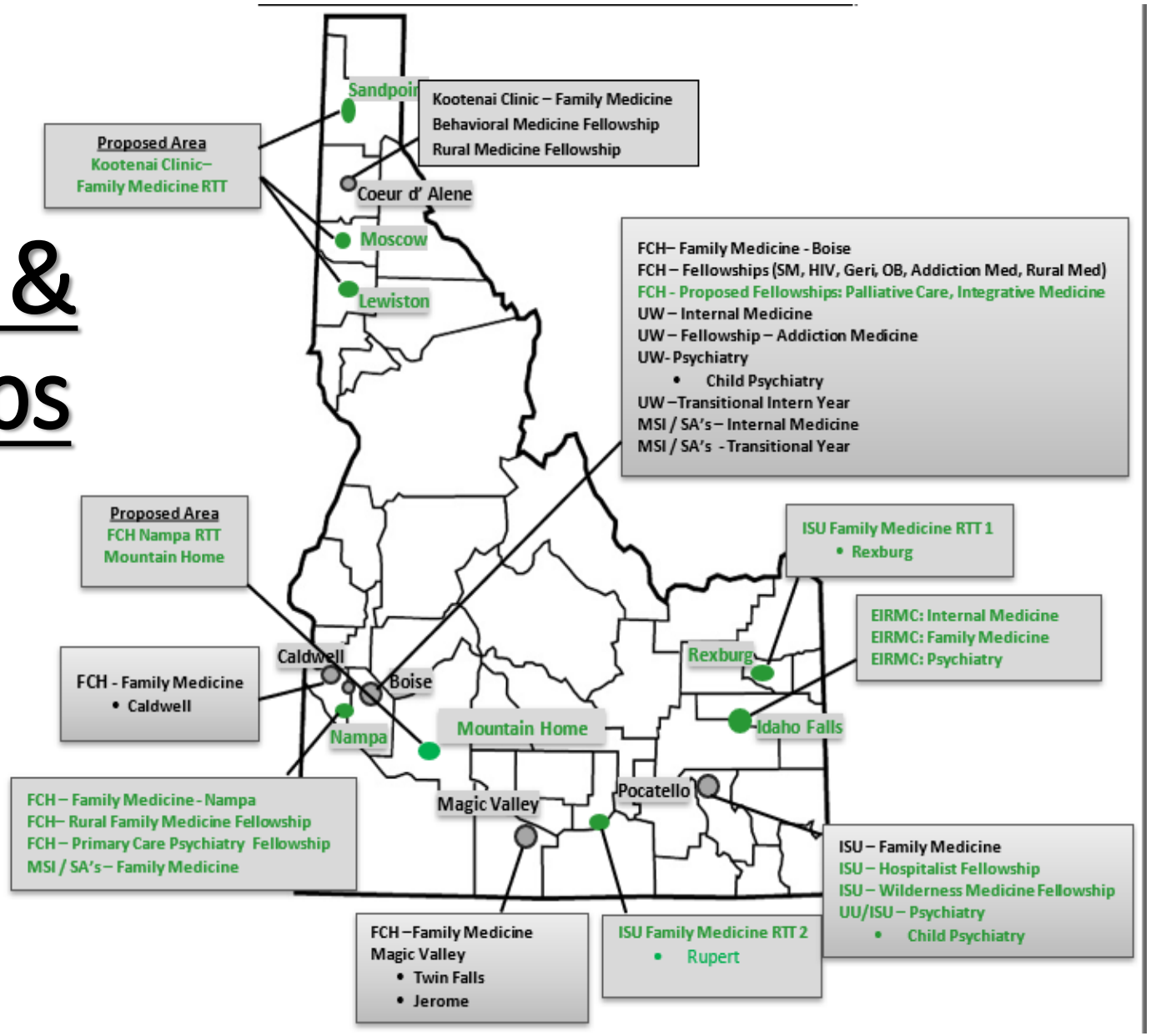
Idaho's Ten Year GME Plan

- 2017 – Strategic Blueprint

Table 15: 12-Year Growth in GME Programs, Residents and Fellows, and Cost to State of Idaho

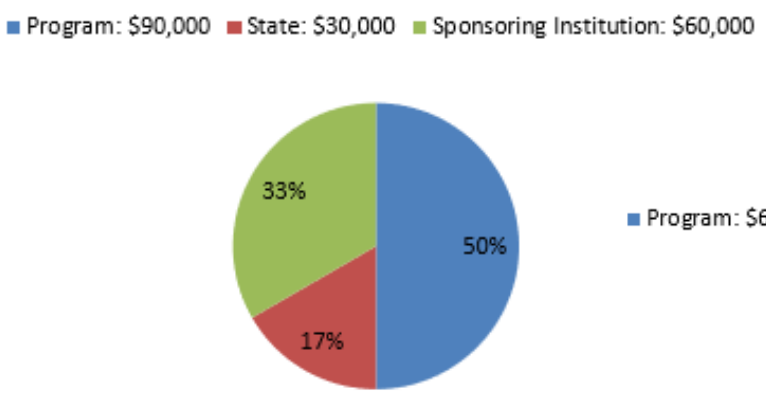
	2017	2022	2030
GME Residency Programs	9	13	21 (Possibly 24)
GME Fellowship Programs	4	10	16
Residents and Fellows Training in Idaho/year	126	243	389
Number of Graduates Each Year from Idaho's GME Programs	46	78	149
GME Residents per 100,000 citizens in Idaho	6.7 (National Average is 28.1)	13.8	20.0 (Assuming Idaho's Population grows to 2 million People by 2030)
Cost of GME and Additional Healthcare Programs in Idaho	$5,138,700 per year	$11,157,000 per year	$20,200,000 per year

Idaho's Programs & Fellowships (2030)



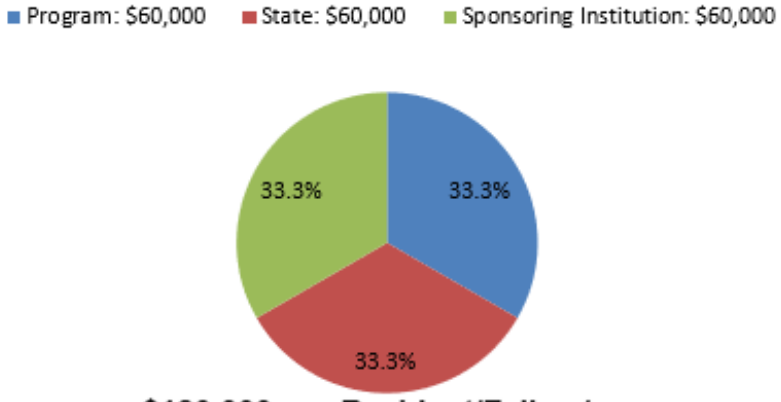
IDAHO RESIDENT / FELLOW FUNDING PER YEAR

Before 2017



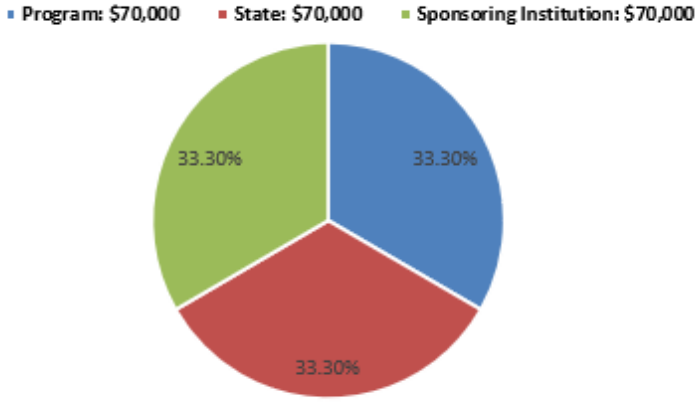
$180,000 per Resident/Fellow/year

2018 to 2022



$180,000 per Resident/Fellow/year

2023 and Beyond



$210,000 per Resident/Fellow/Year

Return on Investment (ROI)

- **8 to 1!**
- **Match 2:1 by Programs and Sponsors**
- **Skin in the Game!**
- **Each Physician**
  - **$1.2M States Economy/Yr ($1.15B)**
  - **10 New Jobs (7,200 new Jobs)**
- **Provide Timely Access, Improved Healthcare, Quality and Healthier Communities for Decades to Come.**

Idaho GME Dashboard and Metrics

Program	First Graduating Class	100% Fill Rate Intern Class	ACGME Accreditation	Graduates Practicing in Idaho as Measured by Rolling 5-year Average. ≥50% - Fam Med ≥40% - Int Med ≥30% - Psych ≥30% - Emerg Med ≥30% - Surgery	Graduates in continued fellowship training outside of Idaho	≥30% of Graduates in Idaho Serve in Rural or Underserved Areas by Rolling 5-year Average		≥80% Board Certification Pass Rate for Graduates as Measured by Rolling 5-year Average
						Rural	Urban Underserved	
Full Circle – Boise	1976	100%	Yes	31 of 56 / 55%		5 of 31 / 16%	20 of 31 / 65%	45 of 45 / 100%
Full Circle – Fellowships	1999	100%	Yes	12 of 19 / 63%		1 of 12 / 8%	9 of 12 / 75%	19 of 19 / 100%
Full Circle – Caldwell RTT	1998	100%	Yes	10 of 14 / 71%		3 of 9 / 33%	5 of 9 / 56%	14 of 14 / 100%
Full Circle – Magic Valley RTT	2012	100%	Yes	7 of 10 / 70%		3 of 6 / 50%	3 of 6 / 50%	10 of 10 / 100%
Full Circle – Nampa	2022	100%	Yes	5 of 6 / 83% (1 year of data)		2 of 6 / 33% (1 year of data)	2 of 6 / 33% (1 year of data)	6 of 6 / 100% (1 year of data)
ISU – Pocatello	1994	100%	Yes	19 of 35 / 54%		8 of 19 / 42%	9 of 19 / 47%	35 of 35 / 100%
ISU – Rexburg RTT	2022	100%	Yes	1 of 1 / 100% (1 year of data)		0 of 1 / 100% (1 year of data)	1 of 1 / 0% (1 year of data)	1 of 1 / 100% (1 year of data)
Kootenai Family Medicine	2017	100%	Yes	23 of 30 / 77%		5 of 23 / 22%	11 of 23 /48%	30 of 30 / 100%
Boise Internal Medicine/Fellowship	2014	100%	Yes	23 of 41 / 52%		1 of 23 / 4%	5 of 23 / 15%	31 of 38 / 82%
Western Idaho Psychiatry	2010	100%	Yes	14 of 18 / 77%		0 of 18 / 0%	14 of 14 / 100%	14 of 15 / 93%
EIRMC Internal Medicine	2021	100%	Yes	6 of 19 / 32% (2 years of data)		1 of 6 / 17% (2 years of data)	1 of 6 / 17% (2 years of data)	5 of 7 / 71% (1 year of data)
EIRMC Family Medicine	2023	100%	Yes	NA		NA	NA	NA
EIRMC Psychiatry	2026	100%	Yes / Initial	NA		NA	NA	NA
U of U/ISU Psychiatry	2024	100%	Yes	NA		NA	NA	NA

Key: Green – measure met measure Yellow – measure nearly met Red – not meeting

Summary

- Be Creative and Innovative
- Talk with State Leaders
- Get Stakeholders / Partners Aligned
- Put Together a Plan / Blueprint
- Skin in the Game
- Speak with One Voice

Teaching Health Center Funding in a Nutshell

Russell Maier, MD, FAAFP

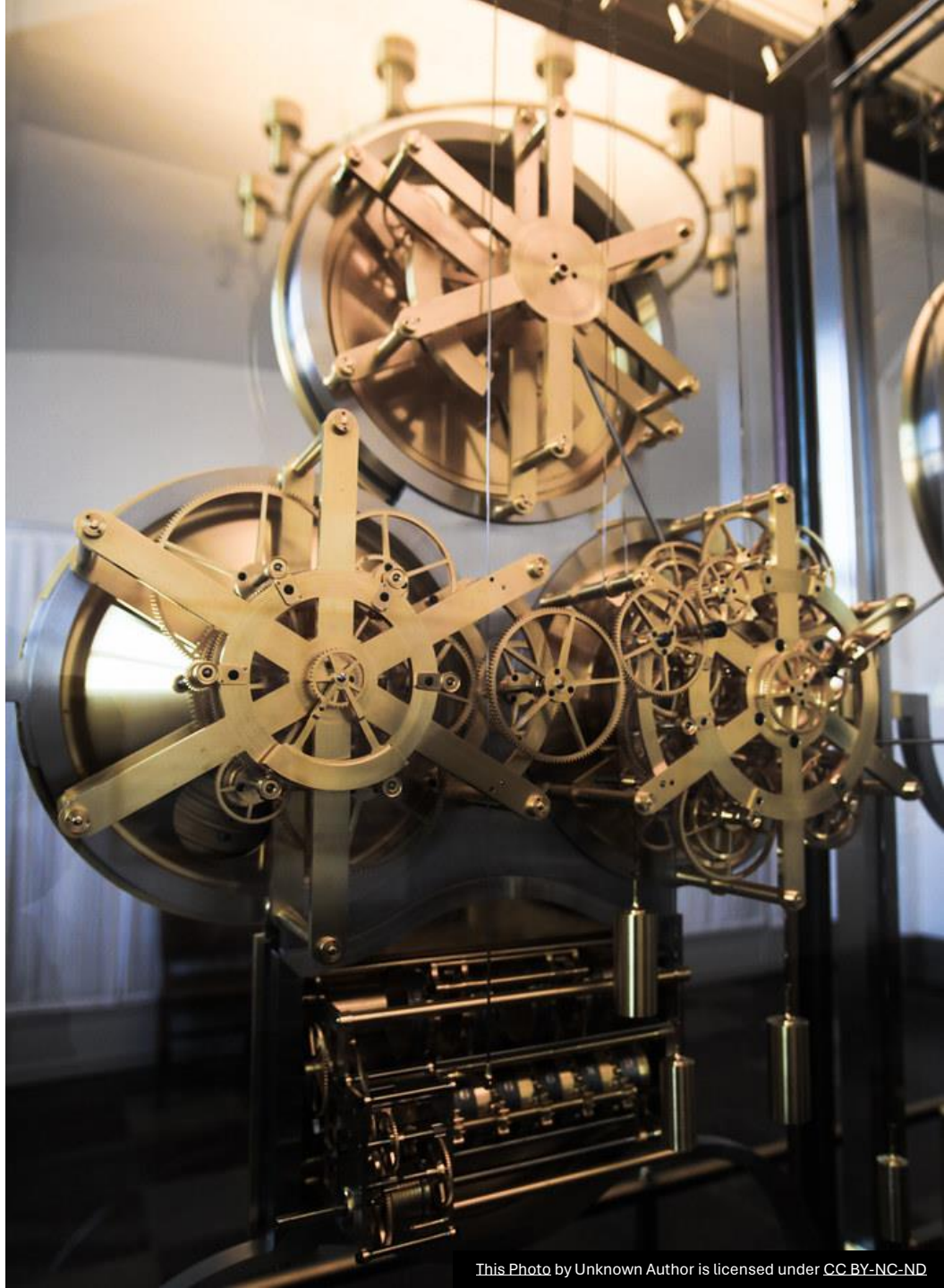
Assoc Dean GME PNWU-COM

Why was it needed

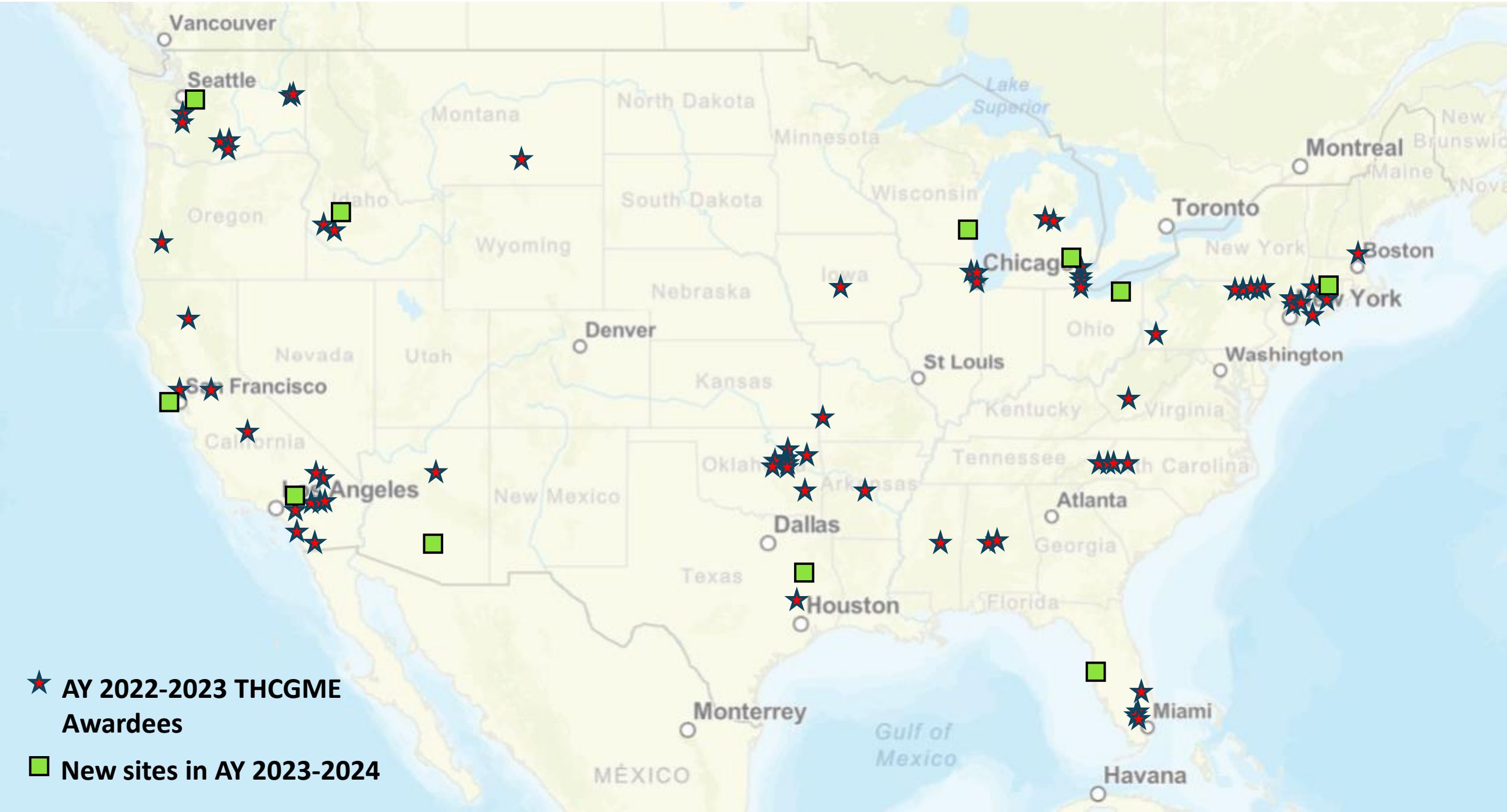
- 2000’s
  - Primary Care Growth Capped
  - Rural constricted
  - Maldistribution Continued
- A new way funding
- Public health need

How it works

- $160,000 per year per Resident
- Follows the resident – not location specified
- Eligible Entities
  - Tribal
  - Rural Clinics
  - FQHC’s
- Eligible Specialties
  - FM, IM, Peds, OB/Gyn, Psychiatry, Geriatrics



THCGME Program Award Recipients



Teaching Health Center Graduate Medical Education

Post-Graduation Practice Location	THC Program Graduates	Other Program Graduates
Rural area	**17.9%**	11.8%
Within 5 miles of residency	**18.9%**	12.9%
Medically underserved communities	**35.3%**	18.6%
In FQHCs or Look-Alikes	**26.7%**	11.7%

Davis CS, *et al*. Evaluating the Teaching Health Center Graduate Medical Education Model at 10 Years: Practice-Based Outcomes and Opportunities. *Journal of Graduate Medical Education* (2022 Oct)

Teaching Health Center Graduate Medical Education

By the Numbers

2011 2023

11 ⇨ 84

Teaching Health Centers

2023

80%

of grantees are FQHCs/Look-Alikes

Since 2011

2,027

new primary care physicians and dentists

Since 2011

7.9 M

hours of patient care in medically underserved and rural settings

since 2011

65%

of graduates go into primary care

2022 2023

47 ⇨ 93

Teaching Health Center Planning and Development Grantees

Teaching Health Center Graduate Medical Education

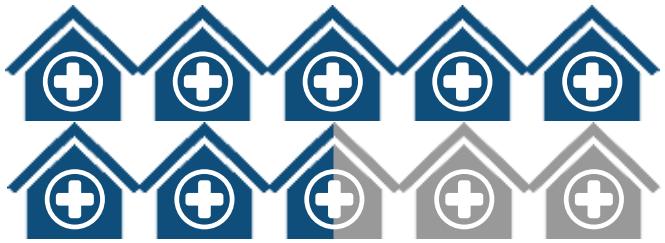
By the Numbers

Since 2011, residents have provided:

4.1 M
patient encounters
in primary care settings

7.9 M hrs
of patient care
in rural and medically underserved communities

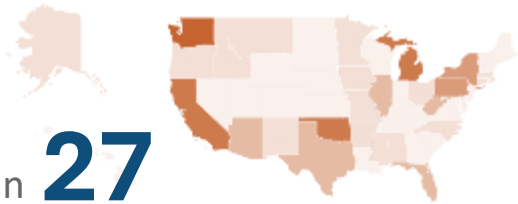
2023 Grantees:



76%
of grantees
are FQHCs or Look-Alikes

Funding supports:

82
residency programs



in **27** states

Clinical training site details:

635
rotation sites

63%
in medically underserved communities

50%
in primary care settings

19%
in rural areas

FQHC = Federally Qualified Health Center

Outcomes

- More likely to work in underserved/rural areas
- More likely to stay where trained
- Broader Scope of Practice
- ACCOUNTABLE

- Risks
  - Annual Appropriation
  - Often doesn't cover the full cost