Pathways in Rural Program Development: *Mission and Money*

Judith Pauwels, MD

University of Washington School of Medicine

HRSA Technical Assistance Center Advisor

Disclosure

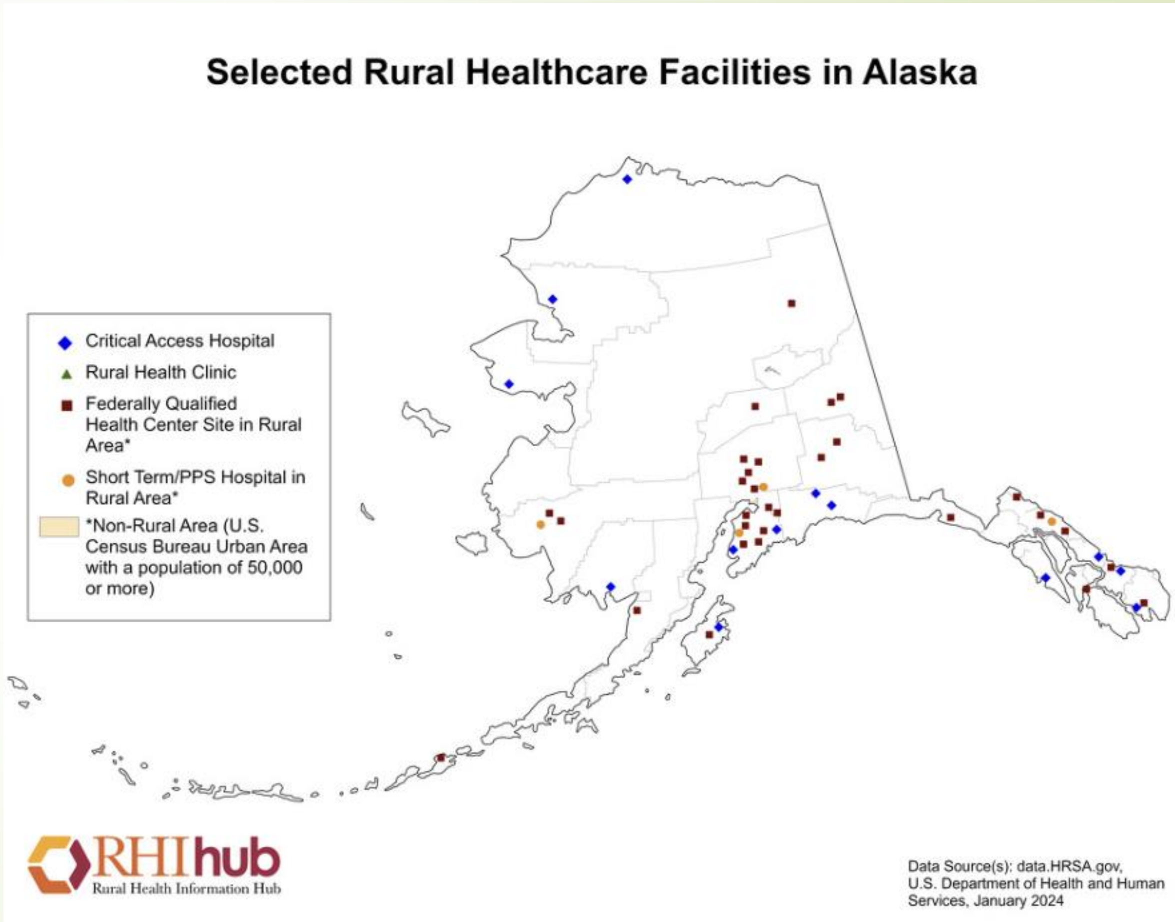
The Rural Residency Program Development – Technical Assistance Center (RRPD-TAC) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement #UK6RH32513. The contents are those of the presenter and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the US Government.

Goals

- Discuss mission and governance in residency programs, and how that relates to program financing.
- Provide an overview of important elements of residency program financing.
- Identify opportunities and strategies for developing new programs, training tracks, and program expansion, particularly for rural and underserved communities.

The Real Goal

- Enhance conversations about workforce development in our rural and underserved communities.



Who is in the room?

- Associated with:
  - Rural communities
  - Urban communities
  - Indian Health Service, or serving Native communities
  - CAH or REH hospitals
  - Existing residency program
  - Hoped-for new residency program

What are your questions?

Different ways for hospitals and clinics to engage in resident or fellowship training

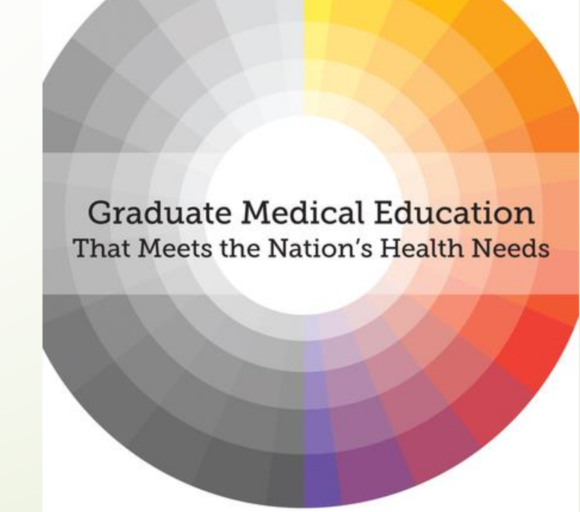
- Resident/fellow rotations
- Training tracks (associated with existing programs)
- Rural training programs
- Core residency programs
- Fellowship programs

Mission

- What drives your interest in graduate medical education?
- Who are the stakeholders who are most invested in this mission?

Governance

- **Responsibilities of a Sponsoring Institution:**
  - "…commitment to GME by ensuring the provision of the necessary administrative, educational, financial, human, and clinical resources."



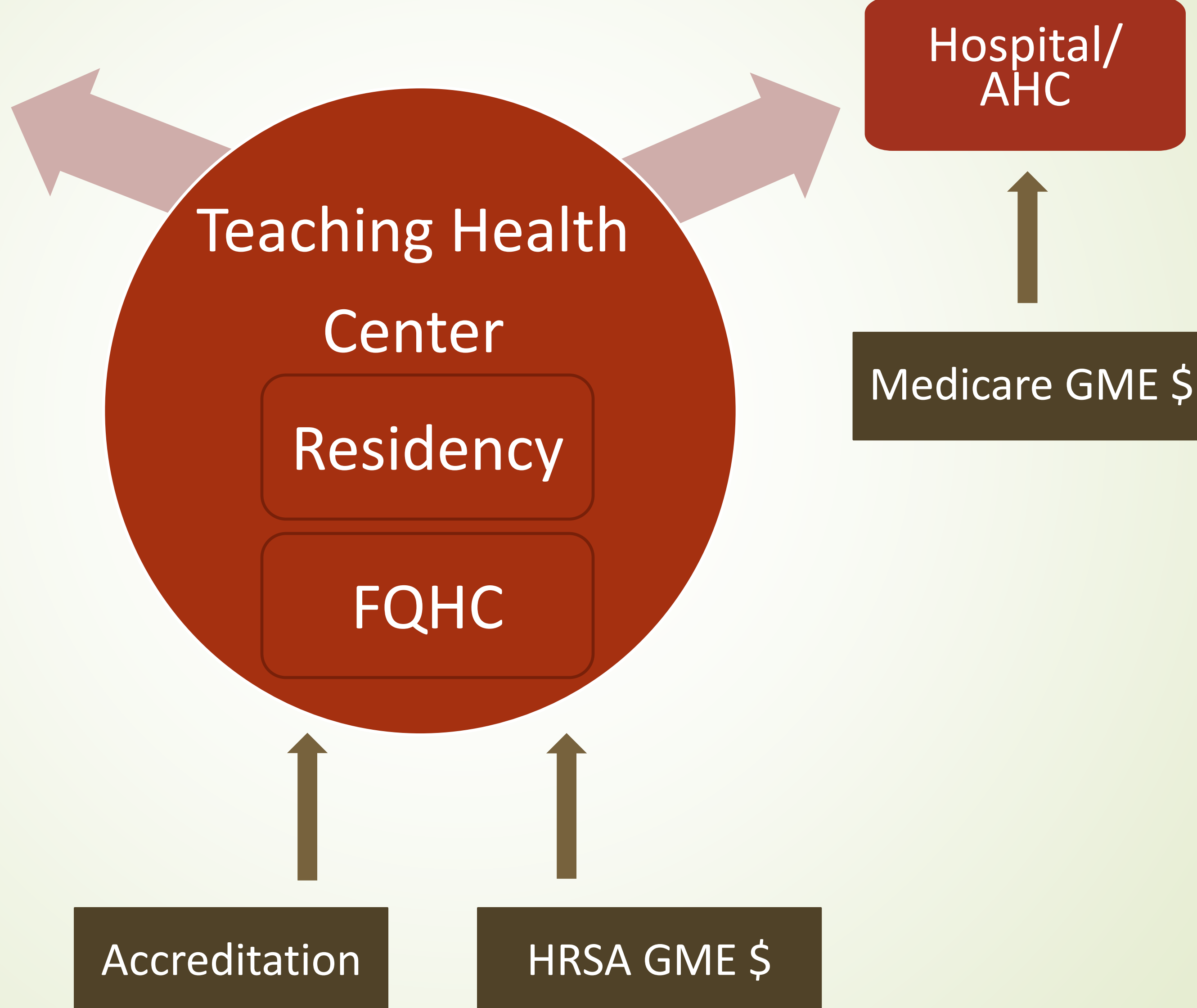
Governance structures

- **Sponsoring Institution for the residency program**
  - Hospital
  - Clinic system
  - AHEC
  - Medical school
  - CONSORTIUM
- **Participating institutions**

GME Consortium

- Two or more organizations who come together to assemble and maintain all of the resources: people, places and funding, to start, operate, and maintain graduate medical education training programs.
- **THC GME consortia** are formal associations of community-based training sites (such as FQHCs), medical schools, teaching hospitals, and other organizations involved in residency training, with central support, direction, and coordination allowing members to function collectively.

THC Model



Mission and Money

- Program funding is complicated, and related to:
  - Structure of the program
  - Clinical entities involved in training (hospitals; clinic systems)
  - Type of hospitals involved:
    - Urban/rural
    - IPPS, SCH, CAH, REH
    - VA and IHS
  - Specific history of prior GME funding for those entities
  - Sources of funding available:
    - Federal
    - State
    - Other

Mission

- What drives your interest in graduate medical education?
- Who are the **stakeholders** who are most invested in this mission?

About the Money…

The “cost” of residency training programs

- Revenues vs expenses as “cost center”
- Revenues vs expenses more broadly as part of institutional strategy:
  - Service
  - Community benefit

Start-up vs sustainability costs

- Start-up: Developing the program until the first resident begins training
  - **Start up funding: need grants!**
- Initial program years: The initial years of the program before all classes of residents in place
  - More expensive per resident
- Mature program: All years of residents in place at full complement
  - **Sustainability funding for ongoing program**

Residency expenses

- Salaries and benefits
- Variable operational expenses
- Fixed expenses
- “Indirect” expenses or “overhead”: other costs not directly on the budget sheets but contributing to the support of the program

Residency expenses: Salaries and benefits

- **Faculty**
  - ***How many?***
  - ***What salary?***
  - ***What expectations?***
- Residents
- **Program coordinator / administrator** and other support staff
- Stipends for other teachers (specialists, preceptors, etc.)
- **FMC staff**
  - Additional for residency training
  - Social work, pharmacy, behavioral health
- **Other personnel**
  - Institutional oversight
  - Financial specialist
  - IT specialists

Residency expenses: Operational

- **ACGME accreditation and NRMP enrollment fees and expenses**
- Resident training expenses
  - Licensing, courses, CME, food, etc.
  - **Recruitment**
- Faculty and staff expenses
  - **Development**, courses, CME, etc.
  - **Recruitment**
- **IT expenses**: hardware and software
- Medical and non-medical supplies, pharmacy, transcription, etc.
- Space utilization
- Malpractice and other insurances
- *OTHER*

Residency Expenses: the "Bottom Line"

- **What IS the estimated average cost per resident for training?**
  - **$180,000 - $210,000 per resident per year….**
- Although there are efficiencies possible, it's important to know where NOT to compromise your budget:
  - **Faculty**
  - **Staff**
  - **Educational resources for quality training environments**

How does an institution afford this???

Residency revenues

- *Patient care reimbursements*
  - *Family medicine clinic/practice*
  - *Inpatient, nursing home, other*
- *Other service reimbursements*

- **Federal CMS GME funding (Medicare; Medicaid)**
- **State Funding (Medicaid GME; other)**
- **Other federal sources (HRSA; VA; others)**
- **Grants, foundation support, other sources**

Federal revenue streams

- CMS: Medicare GME
- Medicaid GME
- Other federal sources
  - HRSA
    - Teaching Health Center grants
    - Primary Care Training Expansion grants
    - Other grants
  - Veterans Administration
  - *IHS*

CMS GME: *what* is it?

- Payments TO HOSPITALS for support of <u>accredited</u> GME training programs
  - Includes both residencies and fellowships
- Medicare’s “share”
- Regulations and payments are <u>specific</u> to individual hospitals

CMS GME: *what* is it?

- **DGME (Direct GME):** intended to pay for the costs of the program and residents
  - Based on "per resident amount" (PRA)
    - PRA set in <u>first</u> full year of resident presence
  - # residents in "cap"
  - Medicare "fair share"
- **IME (Indirect GME):** intended to compensate hospitals for the "inefficiency" of trainees
  - Based on "intern/bed ratio"
  - # residents in "cap"
  - Add-on to Medicare DRG payments

CMS GME: what about the “caps”?

- Caps are the maximum number of residents/fellows that CMS will pay for per year to a given hospital
- An IPPS hospital’s cap was set in 1996, or is established after a five-year time period of training residents
- CAHs and REHs do NOT have caps!
- Rural hospitals (including RRCs) have greater flexibility to get new cap when starting new GME programs
- Urban hospitals can get additional cap for starting new rural training programs
- **Under revised rule in 2020, a GME-naive hospital does not start a “cap clock” until training >= 1.0 FTE**

CMS GME: *notable variations*

Multiple rules govern the ability of a hospital to claim new CMS GME monies:

- Rural vs urban hospital designation
  - Rural can get new cap for new programs
- Urban hospitals can get new cap for "Rural Training Programs"
- **"Type" of hospital (different rules for Sole Community; Critical Access Hospitals; Rural Emergency Hospitals; Medicare Dependent Hospitals; Lugar; other)**
  - SCH/MDH: often only able to claim DGME unless Medicare Advantage penetration

Hospital Type Matters!

Provider Type	Number of Providers	Definition	Percent Rural	DGME	IME	Hospital Specific Rate
Inpatient Prospective Payment Hospital	1911	Acute care hospital predominantly located in an urban area	7%	Yes	Yes	No
Rural referral center	619	Acute care hospital meeting several qualifying criteria based on location, bed size and/or referral patterns	12%	Yes	Yes	No
Indian Health Services	25	Hospitals administered through the Indian Health Care System	**72%**	Yes	Yes	No
Medicare Dependent Hospital	145	Hospital meeting certain criteria including operation of 100 or fewer beds, is not a SCH, and percentage of Medicare patients	**78%**	Yes	Yes*	Yes
MDH/RRC	32	MDH with RRC status	**41%**	Yes	Yes*	Yes
Sole Community Hospital	302	Hospital meeting certain criteria including geographic proximity to other hospitals and travel time	**85%**	Yes	Yes*	Yes
SCH/RRC	162	SCH with RRC status	**71%**	Yes	Yes*	Yes

* Receipt of full IME is dependent on whether the hospital is paid at a higher, hospital specific rate.

CMS GME: *CAH/REH*

- No cap or PRA
- Direct GME payments uses cost-based reimbursement, Medicare share plus 1%, based on where the residents are actually training
- Urban hospital linkage: can be claimed by urban teaching hospital on its cost report for both DGME and IME

CMS GME: *the "rural penalty"*

Rural hospitals usually paid significantly less than urban hospitals

"Rural Physician Workforce Act of 2024"

CMS GME: how *much* is it?

- How do you research your local hospital?

- Lookup hospital provider number:
- https://data.cms.gov/tools/medicare-inpatient-hospital-look-up-tool

- Step by Step Guide to Hospital Type and Status Lookup:
- https://portal.ruralgme.org/toolbox/tools/7

- HCRIS data tool:
- https://portal.ruralgme.org/toolbox/tools/7

- Graham Center Data:
- https://www.graham-center.org/maps-data-tools/gme-data-tables.html

Medicaid GME

- Medicaid GME: state determination whether a state distributes any of its Medicaid revenues for GME
- That state decides how the money will be distributed to its state GME programs
- However, the federal government MATCHES state Medicaid investments by various percentages
- *UPCOMING PANEL DISCUSSION TO DISCUSS THIS!*

Other federal sources

- **HRSA**
  - **Teaching Health Center grants (positions)**
  - Primary Care Training Expansion Development grants (project funding)
  - RRPD/THC Program Development grants (start-up funding)
  - Children's hospital GME (positions)
  - Other grants

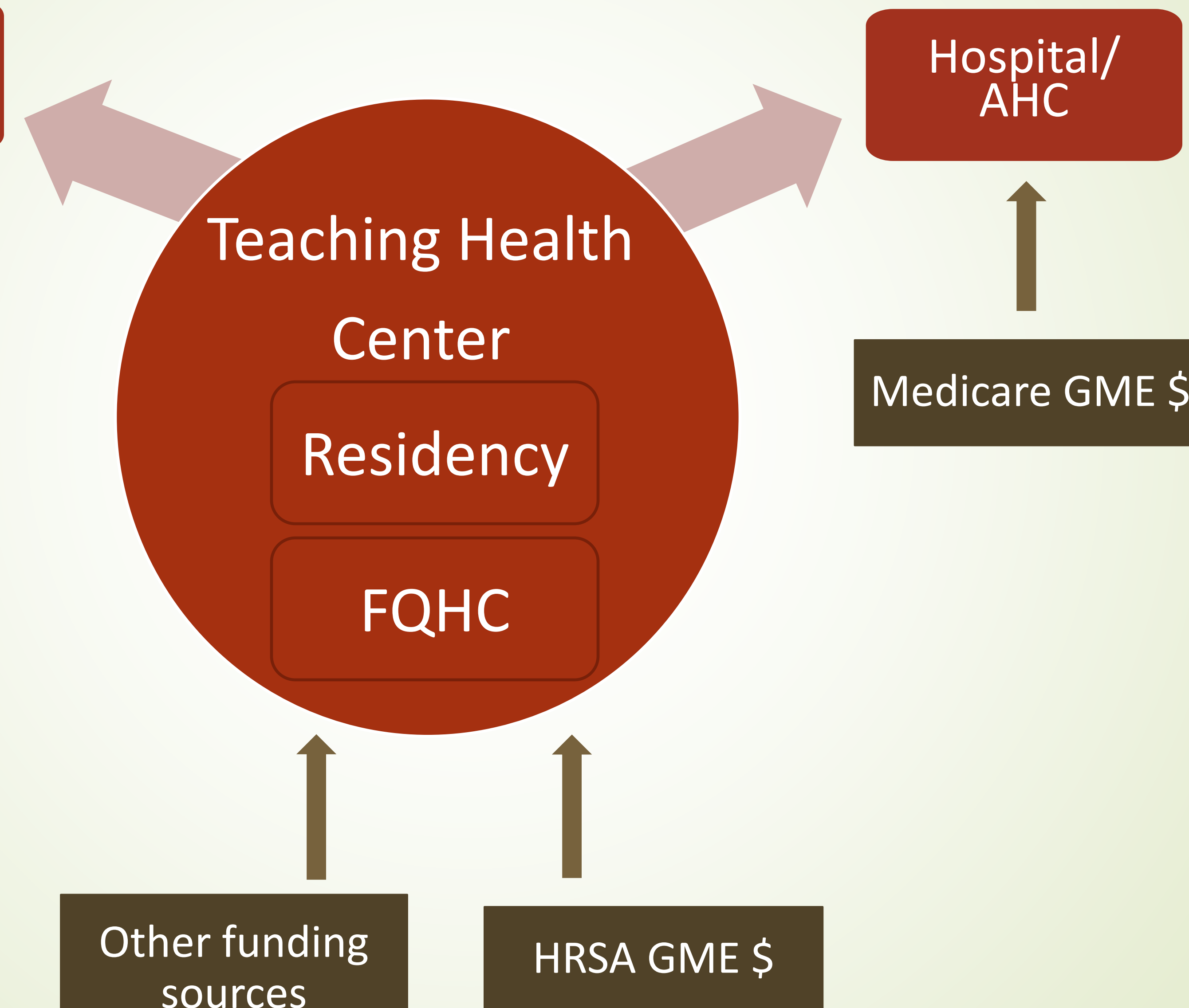
Other federal sources

- **Veterans Administration**
  - VACAA
  - "Mission Act": *pilot program*
- **Indian Health Service**

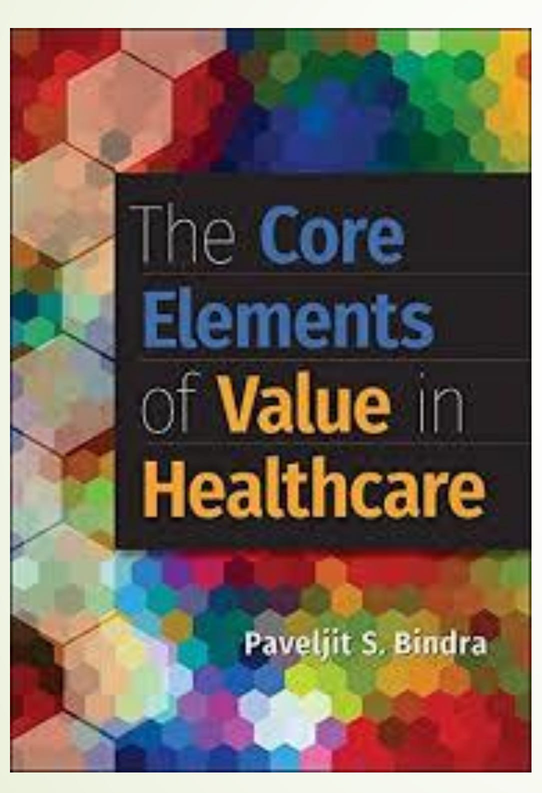
Other funding sources

- **State funding**
- Other sources:
  - Community Support
    - Foundation
    - Individual
  - Grants
  - Research
  - Other
- **Institutional direct support**

THC Model



What is the value of GME programs?



Value = benefits/costs

(i.e., Program Impact / Finances

Program Impact

- Service to community
- Service to the hospital/system
- Physician workforce contributions
- Improving quality of care

Opportunities and Strategies for New Rural Physician Workforce

Opportunities and Strategies for New Rural Physician Workforce

- Embrace the mission of developing the future physician workforce needed to serve rural and underserved communities.
- Engage in medical education at both the medical student and graduate medical education levels.
- Develop a leadership/stakeholder team to pursue GME program development.
- Evaluate both the accreditation/educational requirements AND the financial possibilities for supporting new program development.

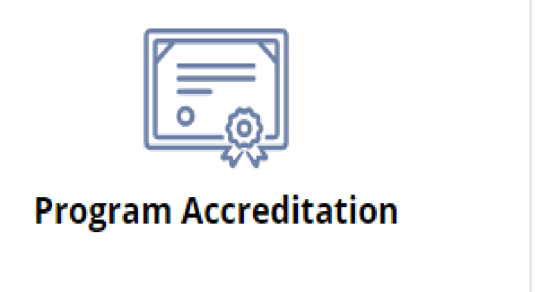
Domains of Development

Community Engagement

Program Design & Development

Financial Planning

Institutional Sponsorship



Program Accreditation

Program Implementation

Roadmap for Rural Residency Development

Stage 1: EXPLORATION	Stage 2: DESIGN	Stage 3: DEVELOPMENT	Stage 4: START-UP	Stage 5: MAINTENANCE
Community Stakeholders Identify interested parties **Sponsorship** Establish an institutional affiliation or sponsorship and locate a primary training site. Begin to consider financial options. **Rural Mission** Determine the reason for developing this program.	**Educational & Programmatic Design** Consider community assets, educational vision, resources, accreditation timeline. **Financial Planning** Develop a budget and secure funding. Consider costs of start-up, phase-in, and mature program. Identify rever[illegible]tions **Sponsoring Institution Application** Find a Designated	**Achieve Sponsoring Institution Initial Accreditation** **Obtain Program Accreditation** Hire key personnel (coordinator); develop curricular plans, including goals and objectives for required curriculum; evaluation system and tools; policies and procedures; program letters of agreement (PLAs); faculty roster. Comple[illegible] ACGME applicati[illegible]prepare for [illegible].	**Program Personnel & Resources** Hire core faculty and other program staff. Faculty development. Complete any construction and start-up purchases. Establish annual budget. **Marketing & Resident Recruitment** Create a website, Register with required systems. Market locally [illegible] [illegible]ionally. **Matriculate** Welcom[illegible]nt new r[illegible]	**Ongoing Efforts** Report annually to ACGME, Sponsoring Institution. Maintain accreditation. Annual budgeting and reporting. Track program outcomes.
To advance to the next stage: Make an organizational decision to proceed with investing significant resources in program development.	**To advance to the next stage:** Complete program design to include curriculum outline and site mapping Submit an SI application Finalize a draft budget	**To advance to the next stage:** Achieve initial program accreditation – requires successful site visit and letter of accreditation from the ACGME	**To advance to the next stage:** Complete contracts and orient first class of residents Hire all required faculty	

Where to get information and support

- State GME Councils
- Other programs
- ACGME
- Primary Care Associations
- NACHC/AATHC
- AHECs
- Hospital associations
- WWAMI Network
- RTT Collaborative
- HRSA websites:
  - RuralGME.org
  - THCGME.org

QUESTIONS

jpauwels@uw.edu