# CONSIDERATIONS REGARDING GRADUATE MEDICAL EDUCATION (GME) CONSORTIA DEVELOPMENT

## GME Consortium:

A group of organizations working together to design and operate, a thriving, high quality ACGME-accredited GME program.

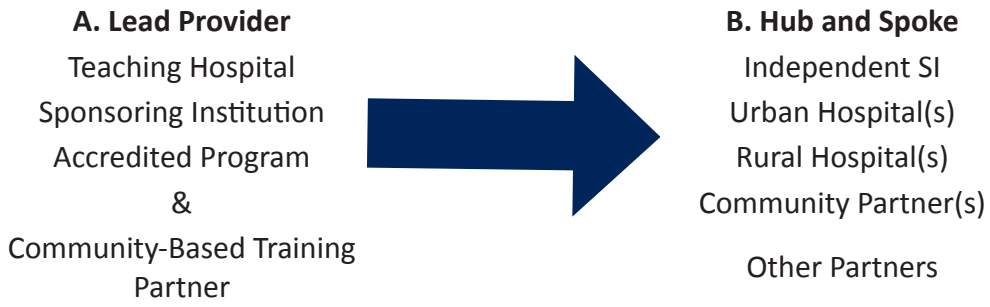
## GME Consortia can take many forms.

They are shaped around the needs of strategic or relationally identified partners to meet their mutual interests in GME programming. They are flexible in design and take on the characteristics or values of each partner that support the best model for sustainable, high-quality training. Primary considerations include experience or desire to create an accreditable GME model that is financially viable, while assuring a long-term commitment to the partnership or affiliation.

## Key GME Consortium Concepts:

- Recruitment
- Training Excellence
- Financial Benefit
- Start Up Costs
- Partnership/Commitment

**Continuum of Engagement Models in a GME Consortium**




In example A., which may be the most common form of training model outside of the Teaching Hospital, the Teaching Hospital receives GME financing from Medicare and/or other sources, serves and the Governing Body for the Sponsoring Institution (SI) / Graduate Medical Education Committee (GMEC), employs the Designated Institution Official (DIO) and "owns" the accredited program. Via affiliation

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agreement and contract, the SI partners with a community-based organization (CBO) to train residents in an expansion of an existing program or through the development of a new, separately accredited program under the SI.

In Example B., independent partners / providers come together to establish a Governing Body and a SI in a formal, new, neutral Consortium, which is not a provider of health care services. Through by-laws they create a separately organized or reorganized non-profit or for-profit organization, including all members of the group. The design may be expandable to include new partnerships or programs. The partners share costs and democratic decision making based on the organizational model.

## Choosing Partners

### Principles of Engagement / Common Interests

- Mission to Increase Access to Health Services / Workforce Development
- Minimize Competition / Duplication / History of Collaboration
- Sharing Clinical locations and Resources
- Cost and Revenue Sharing
- Shared Decision Making
- Supporting Cost Efficiencies
- Sustaining Infrastructure
- Quality / Outcomes Focused

### Finding Partners

- Use State, AHEC, AACHC, AZ Hospital Association or others to identify possible partners or internal resources of initiating entity.
- Knowledge of the scope of local, regional and / or statewide GME providers.
- Shared GME vision
- Financial Opportunity – GME financing eligibility Issues understood
- Rational Training Environment (Geography, Capacity, Balance, Collegiality)

### Identify Key Players in each Organization and Move Forward

- Form a Core Group of Stakeholders
- Have meetings to discuss mutual interests in GME
- Hold initial meetings of full group
- Scope of collaboration
- What group wants to achieve
- Shared Goals
- Basic models discussion
- Confidentiality and Trust
- Positive and Negatives
- Practicality
  - Clinical / Training Capacity
  - Resources to Organize
  - Resources to Operate a GME System when Accredited
    - SI
    - Program
- Transparency – All partners agree to fully disclose financial and clinical issues

### Secure Organizational Approval from Each Partner

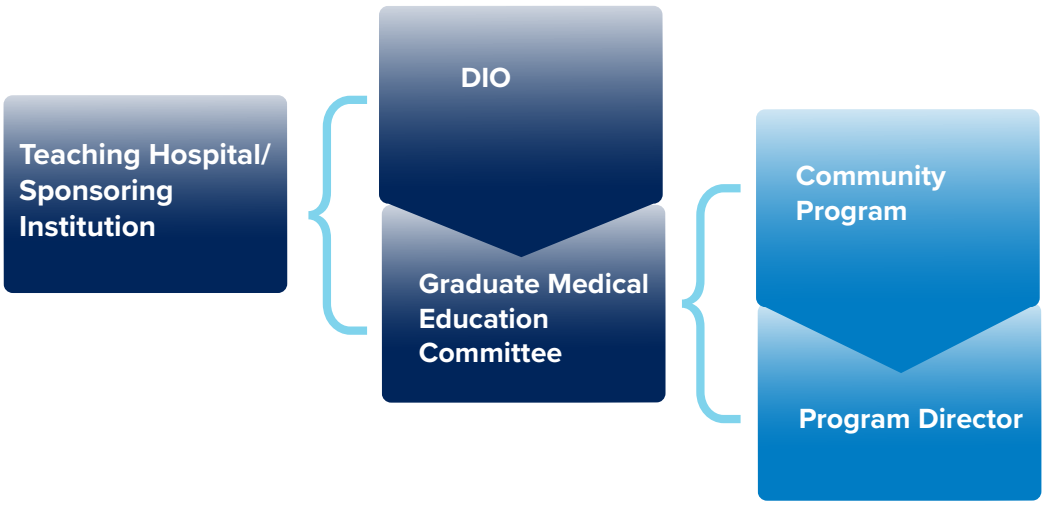
- Is it in the Strategic Plan?
- Is the CEO/CFO/CMO, etc. On-Board?
- Is the Board on board?
- Are potential faculty and staff engaged and committed?

## Organizing Documents

- Vision, Objective and Scope of Consortium training programs
- Roles and Responsibilities of Each Partner
- Action and Timeframes with Responsible Individuals or Organizations
- Resources Available or Identified for Development
- Financial Resources
  - Proforma / Budget Development
    - Medicare GME payments
    - Medicaid Payments
    - Teaching Health Center Resources
    - Internal Resources
  - Cost Allocation
    - Resident Employer
    - Faculty Model
      - Program Director
      - Core Faculty
      - Affiliated Faculty
        - Community
        - Hospital

### Structural Models (see above)

- **Lead Provider Organization**



► **Lead Provider Develops Community Partnership**

The Lead Provider Model is the most common approach. It operates by having a lead organization which obtain and allocates funding on behalf of the consortium based on revenues available. The lead organization also delivers services.

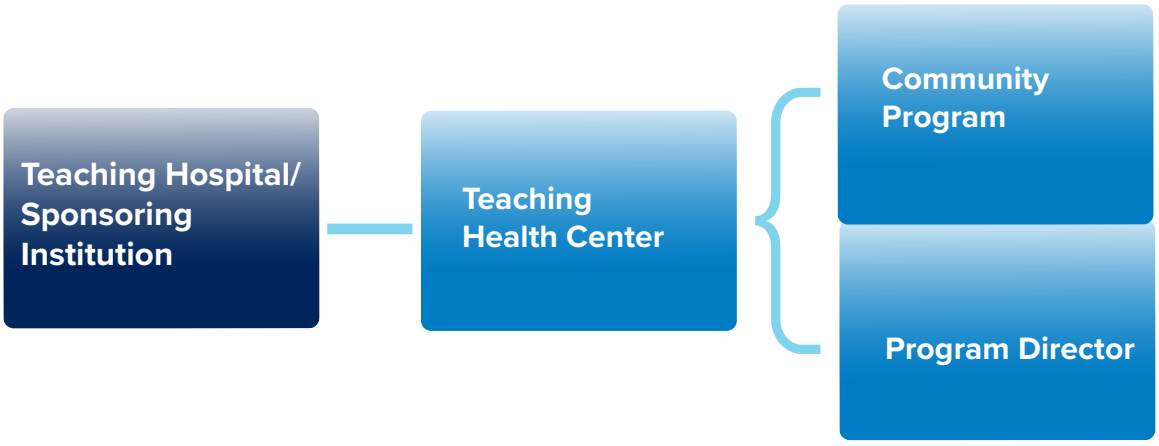
In GME programming, the Lead Provider is typically the Teaching Hospital or Academic Medical Center. It is seeking to expand it residency programs via partnership with external organizations. This is usually possible due to room in Medicare Cap space, reorganization of an urban hospital to a Rural Referral Center in its Medicare Certification, partnering with a rural community hospital or clinical service provider to obtain RTP support in Section 127 of the 2021 ACC or as in the Arizona environment, there is no Medicaid cap and there are sufficient resources in Medicaid IME and DGME payments to account for the cost of program operations.

In this model the external partners are dependent on the lead hospital for program financing and long-term sustainability in many cases. A multi-year contract would be critical as the community training partner must invest a significant amount of resources to ensure sufficient faculty, staff and facilities for training.

Consortium contracts take the form of affiliation agreements, for clinical and accreditation-related services and include a contract for the flow of resources to support resident costs internally and off-site program faculty and related expenses.

A lead organization with multiple community partnerships could consider a tiered structure for its GMEC. This could include for instance, an Internal, hospital-based program GMEC and a subsidiary Regional Partners GMEC which could have an assistant of associate DIO as its lead staff.

► **Community Driven Partnership with Accredited Provider Organization / SI**

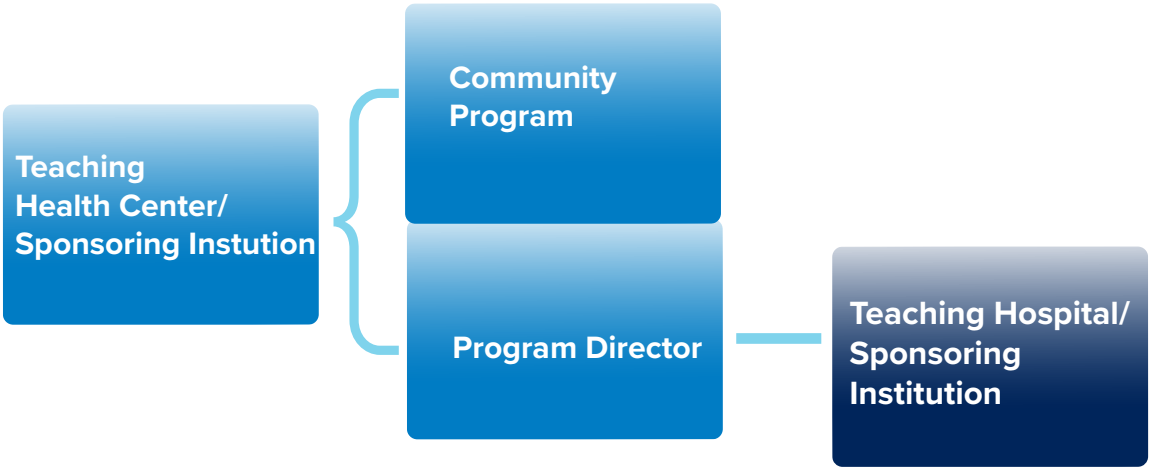



In this more recent model, a community-based provider, an FQHC for example, is seeking to develop a training program with an existing, accredited hospital to partner. The FQHC may have obtained HRSA Teaching Health Center (THC) planning and development, or AzAHEC planning and development, grant funds and intends to apply for operational THC funding when their program is accredited. Assuming the THC provides the residency financing in whole or in part, the Hospital would set up a new, separately accredited program “owned” by the hospital but operated by the THC.  The affiliation agreement for

training and associated contract spells out the financial relationship between the THC and the SI, who employs the residents and faculty, etc. Funds are distributed accordingly. To obtain Federal THC grant funds the THC must have a significant role in the contractual relationship and be in charge of its own future.

(Multiple consortium or training models may exist with one lead hospital in both examples above.)

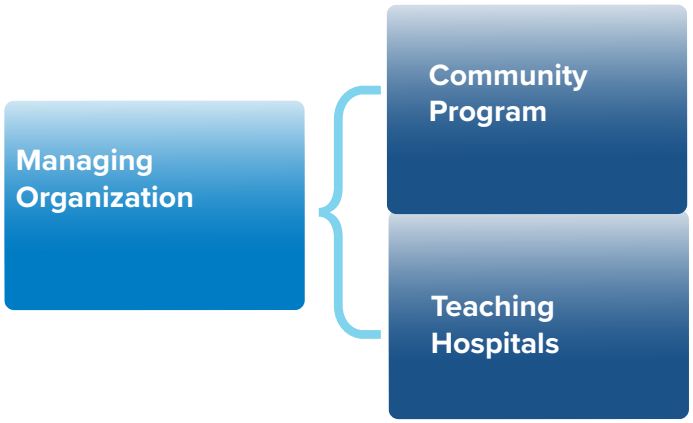
► **THC as the Lead in Multiple THC Consortium**




In this model the THC is the Sponsoring Institution and has resources independent of Teaching Hospital GME payment from Medicare and/or Medicaid or both organizations contribute to the financial health of the program(s). Another difference is that the THC is the SI and "owns" the program. It seeks to contract with a hospital partner for inpatient or subspecialty rotations.

In all Lead Partner models, including the non-"owner" / SI partner in the GMEC or similar decision making and accreditation processes is desirable.

► **Managing Agent Model**

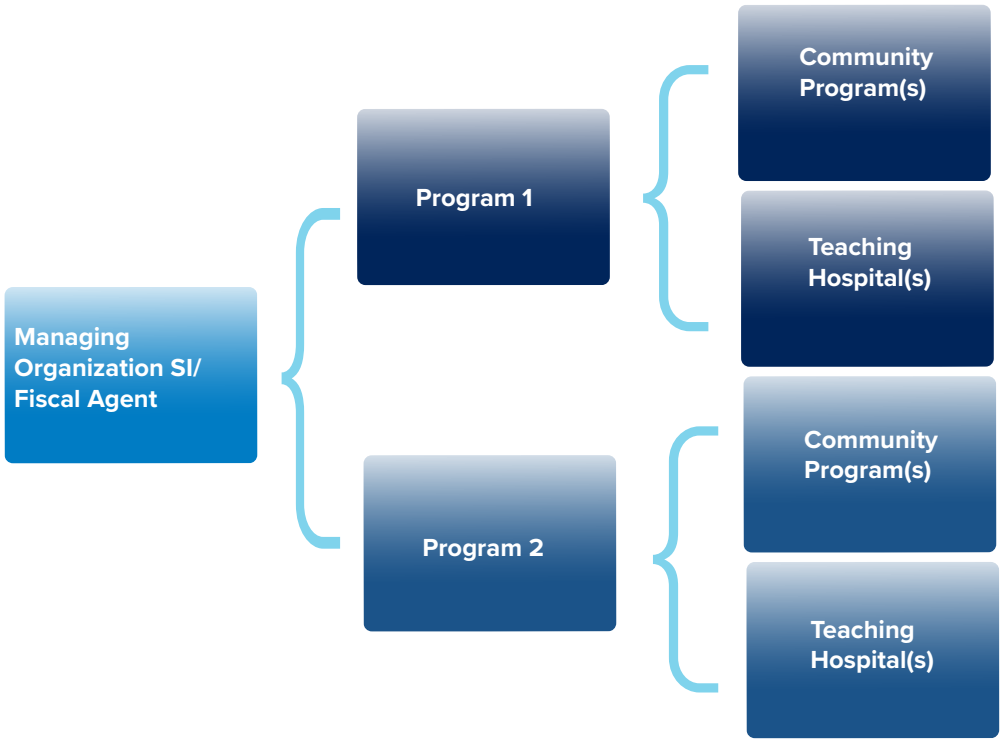



The Managing Agent Model is very similar to the Lead Provider Model in that it has a hierarchical

structure. However, in this model, the Consortium creates a new legal entity or adopts an existing organization that has expertise and shared values.  The new or expanded organization includes all consortium partners and other key stakeholders (e.g., Medical School(s). The new organization serves as the administrative arm of the consortium, Sponsoring Institution and manages / distributes financial resources generate by the provider partners in support of program health and viability.

The key difference is that, in this structure, the lead organization does not deliver any of the services. Instead it applies for funding, manages contracts and manages subcontractors. The lead organization is called the managing agent or partner in this structure.

► **Hub and Spoke Model**




Under this model, the consortium creates a new legal entity for the consortium which serves as the 'HUB" for multiple programs in various locations. Organizations of individual program or spoke consortia members then become formal members of the consortium.

## Structures: Consortia, Affiliation Agreements and Contracts

► **Lead Provider Model**

The Lead Provider Model is the most common approach used by GME consortia. In this model, the consortium does not have a legal identity. Each partner retains its individual identity and the has affiliation agreements or contracts with consortium partners. It operates by having the lead organization, which because of historical financing by Medicare and more recently Medicaid, is typically the Teaching Hospital or Academic Medical Center. It receives payments that support its GME operations and perhaps those of the consortium members.

The Consortium is never specifically organized separately and exists as non-hospital-based organizations

affiliating with the hospital to provide office or clinic-based training. No money changes hands in some cases. The consortium members each have separate affiliation agreements with the Lead Provider. The consortium is comprised of individual organizations providing their agreed upon portion of the training program. Which may or may not include a role with the Governing Body or GMEC.

Because of Medicare CAPS and other reasons, community organizations have historically paid for resident rotations. In other cases, especially since the 2021 changes in CAP opportunities, the GME receiving hospital will pay its consortium members for their role in training. In these types of consortia, one or more partners receive GME payments and distributes resources in support of training, require negotiations, and formal contracts which include specified training requirements in exchange for compensation.

These conditions are similar if the Lead Organization is a Teaching Health Center that receives state or federal residency operating funding or financing other than a Teaching Hospital. It may also be the case that all partners affiliating for training with a lead provider, may receive some GME financing or funding in which case the financial arrangements between members are articulated in a contract. Often and external, or third party consultant is engaged to create a neutral environment for development of a Proforma or Budget which shows the revenue and cost streams of each member or sub-contractor that ultimately become the basis for that aspect of the contract.

Since the lead provider is fiscally responsible for the specific programs and "owns" the accreditation, the training partners can focus of clinical programs rather than administrative responsibilities. The pros and cons / advantages and disadvantages of each Consortium relationship should be discussed by the group(s).

Transparency and confidentiality are critical in every contractual process.

► **Managing Agent and Hub and Spoke Models**

In these models, the Teaching Hospital(s) and community-based organizations, including THCs, have contracts with an independent/non-provider organization. The organization is designed by the consortium members who may allow additional programs into the group to develop additional training capacity in a hub and spoke model. In this way the consortium is a formal agreement between partners that are named in the organization's legal documents like by-laws and Sponsoring Institution Application, including roles on the GMEC. A clinical partner in the Consortium may serve as DIO, another may provide the Program Director. Resources are generated by one or more members who design the clinical model including clinical and hospital experiences, recruitment plans, faculty recruitment and development, resident employment and compensation structures, etc. Revenues of each partner are transparent, based on the best options for financial viability and combined into a proforma that is agreed upon and the basis for contracts between the Managing agent or Hub organization and each clinical partner.

As necessary, the consortium may engage independent or external expertise to design the consortium, affiliation agreements and contracts.

## For more information and technical assistance contact:

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See also the AzAHEC document regarding various affiliation agreements for the provision of GME between partners.