THE UNIVERSITY OF ARIZONA
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Center for Rural Health

Critical Access Hospital (CAH)
Graduate Medical Education (GME) Brief

Centers for Medicare & Medicaid (CMS) designated Critical Access Hospitals (CAHs) are unique Medicare providers with their own Conditions of Participation (CoP) and payment methods.

Traditional hospitals fall under the CMS Inpatient Prospective Payment System (IPPS) for inpatient operating and capital-related costs at CMS specified rates for each hospital discharge. Discharges are coded by Medicare Severity Diagnosis Related Groups (MS-DRGs).

However, Medicare pays CAHs based on each hospital's reported costs[1], using a cost plus 1% model. CAHs submit annual cost reports to establish Medicare and Medicaid payment rates. CAH status as a non-IPPS hospital affects its ability to generate Medicare and Medicaid Graduate Medical Education (GME) payments. There are up sides and down sides to the CAH payment model when it comes to GME subsidies that are discussed below.

To be a CMS designated CAH Medicare-participating hospital it must:

- Be in a state with an established State Medicare Rural Hospital Flexibility (Flex) Program. The AzFlex Program has been in the Arizona Center for Rural Health (AzCRH) since 1999.
- Be designated by the state as a CAH. AzCRH provides technical assistance to hospitals wishing to become a federally designated CAH. Currently there are 17 Arizona CAHs.
- Be located in a rural area or an area that is treated as rural.
- Be 35 mi. or more from the nearest hospital; or be 15 mi. or more in mountainous areas or only secondary roads; or been certified prior to 1/1/2006 as a CAH based on state designation as a healthcare services "necessary provider" to residents in the area.
- Maintain 25 inpatient beds or less for either inpatient or swing-bed services.
- Maintain an annual average length of stay of 96 hours or less per patient for acute inpatient care, excluding swing-bed services and beds that are within distinct units.
- Demonstrate compliance with the CAH CoPs (see 42 CFR Part 485 subpart F).
- Furnish 24-hour, 7 days per week (24/7) emergency care services.

CAHs may or may not have a sufficient scope of practice or the patient capacity necessary to support an independent GME program. There are several fully independent CAH GME training programs in the U.S. However, partnership with urban Academic Medical Centers (AMCs), Teaching Hospitals, or Rural Training Program (RTP) are more common because CAH-based GME programs often need additional clinical resources to be an Accreditation Council for Graduate Medical Education (ACGME) accredited GME program.

IPPS hospitals may generate more Medicare GME payment revenue than a CAH hospital, often making those partnerships more financially viable and sustainable. IPPS hospitals can also claim the resident time at a CAH rather than the CAH if that is the preferred partnership

[1] Critical Access Hospital Payment System. Medicare Payment Advisory Commission (MedPAC) 2021. Accessed at: https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_cah_final_sec.pdf

approach. State Medicaid GME payment systems may help support GME program fiscal viability, and in some cases provide sufficient GME operating resources.

Since CAHs are not IPPS hospitals, they are not eligible for traditional IPPS hospital Medicare GME payment. IPPS Medicare GME payment is comprised of two parts, direct and indirect[2]:

- Direct Graduate Medical Education (DGME) payment is to cover resident stipends, supervisory physician salaries, and administrative costs. These costs are set in the first year of a hospital's GME program, establishing a statutory Per Resident Amount (PRA) that stays with the institution indefinitely or until Congress changes the PRA in statute.
- Indirect Graduate Medical Education (IME) payments are designed to compensate hospitals with GME programs related to "inefficient care," for the higher patient care costs in teaching hospitals relative to non-teaching hospitals. IME comprises two-thirds of the total DGME + IME payment. Dated, complex statutory formulas determine IME payment. The Medicare Inpatient Prospective Payment System (IPPS) allocates IME as an add on per discharge payment to qualifying teaching hospitals.

Medicaid GME Subsidies[3]: Forty-three states and DC have Medicaid subsidized GME programs that are often unique to each state, that must be approved by CMS for federal matching fund purposes. Some states base Medicaid GME payment on the Medicaid share of the institution's payor mix. However, CMS gives states flexibility in developing their Medicaid GME payments.

CAHs, on the other hand, are paid based on their direct costs and are generally paid more for each admission than IPPS hospitals. However, a hospital has to be an IPPS hospital to get Medicare DGME and IME payments; CAHs do not get DGME or IME Medicare payment.

CAHs can claim residency expenses on their annual cost report and will then be paid "Medicare's share" based on an analysis of their Medicare bed days as a percent of total bed days. This is often less than what IPPS hospitals receive via Medicare DGME + IME payments. A rule change in 2019 allows most GME programs from IPPS hospitals to claim the time residents spend in CAHs, and also in federally designated Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). This can make the fiscal case for academic-CAH GME partnerships more attractive.

Thus, IPPS claimed residents that rotate in CAHs and their affiliated RHCS, can translate to higher payment (DGME + IME) at the CAH compared to what the CAH would get via cost-based reimbursement. The claiming IPPS hospital has to demonstrate that it pays for resident time (salary plus benefits) spent at the CAH and RHC. This might entail contracting with the CAH to pay for resident salaries and benefits if the CAH employs the residents. The status of the IPPS Teaching Hospital as it relates to GME will matter when considering payment options.

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[2] Medicare GME Payments: An Overview. Congressional Research Service (CRS) 2022 at: https://crsreports.congress.gov/product/pdf/IF/IF10960

[3] Henderson TM. Medicaid Graduate Medical Education Payments: Results From the 2022 50-State Survey. July 2023. Washington, DC: AAMC.

The Balanced Budget Agreement (BBA, 1997) capped the number of Medicare GME residents. Each IPPS GME Teaching Hospital facility has its own CMS cap. Urban facilities have total caps; rural hospitals have caps by specialty. New hospital GME programs are capped after five years.

The Arizona Medicaid GME program has no caps but does not pay the non-federal share required to draw the Medicaid federal match. Currently Arizona's federal medical assistance percentage (FMAP) is 66.3%, meaning that a 33.7% non-federal share is required to draw the federal Medicaid GME subsidy. That means that for each one dollar in non-federal share, $1.85 is generated in federal Medicaid GME match. How the non-federal share is covered varies – the state can pay for it, the sponsoring hospital can cover it, and in Arizona it can be covered by a state entity – such as a county or one of the public universities (University of Arizona, Arizona State University, Northern Arizona University).

CAHs have no Medicare caps on residency training slots, since they are not subject to IPPS regulations for residency payments. Nor do CAHs have a fixed PRA for DGME as the costs can be included in the cost-based calculations. CAHs unfortunately, do not get Medicare IME, a major fiscal consideration in deciding on CAH - IPPS hospital GME partnerships.

Medicare's share of the hospital's payor mix will determine the percentage of the costs Medicare will cover. So, assessing how Medicare patient load impacts GME costs is an important consideration.

Understanding how the state Medicaid programs can add to GME revenue is also important. The combined Medicare and Medicaid GME subsidies may be sufficient to cover the costs of a residency program.

In Section 127 of the 2021 BBA, Congress created a Rural Training Program (RTP) model that allows IPPS hospitals to add to their resident CAP for developing new programs if greater than 50% of the resident time is spent in an Office of Management & Budget (OMB) Core Based Statistical Area (CBSA) non-metropolitan area.

In order for an IPPS hospital to participate in an RTP, it must be a new residency program in an OMB CBSA designated non-metropolitan area. New RTP programs must have separate accreditation, a program director (PD) not currently listed as a PD on any other program faculty, residents (i.e., unique National Resident Matching Program match number).

If a CAH has a stand-alone or (almost) independent program with rotations in an urban hospital they lose urban rotation months when they claim resident FTE and costs. Those costs may be claimed by the IPPS hospital if eligible. One requirement is that the urban hospital must have three months of rotations per resident training cycle to make the IPPS hospital eligible for GME RTP payments for both IME and DGME.

Different rules apply if the urban hospital is considered a Rural Referral Center by CMS. Thus, each partnership must be assessed to determine the revenue potential of the model. This is important because CAHs may be OMB designated as either metropolitan or non-metropolitan.

Minimum Training Requirements for GME Programs:
Each specialty has unique accreditation requirements which need to be understood. For example, ACGME requires the 3-year Family Medicine residency to include:

- 1,000 hours of care for Family Medicine Practice (FMP) patient
- Long Term Care experiences over 24 months
- Patient panels – 10% pediatrics patients and 10% older adults
- Team Based Care
- 100 hours / one month (block or longitudinally) of acutely ill children
  - 50 inpatient encounters with Children
  - 50 ED encounters with children
- 100 hours / one month OB and Gyn (selected requirements)
  - Ob/Gyn
  - Family Planning
  - Contraception
  - Education on options for unintended pregnancy
  - 20 vaginal deliveries
- 400 hours and 80 deliveries (direct or supervised) for Ob certification
- 600 hours / 6 months longitudinal and 750 patient encounters for adult inpatient
- 100 hours / 125 patient encounters in the ED
- 100 hours / 125 patient encounters of older adults in a variety of settings
- Care of Surgical Patients (pre-operative and post-operative, assessments)
- Care of patients with a broad range of Musculoskeletal Problems
- Care of patients with Dermatological problems with common procedures
- Behavioral Health and team care (MH and substance use disorders)
- Pharmacological training
- Community Health
- Diagnostic Imaging including point of care ultrasound
- 6 months electives

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