GME Financing 101

Onward through the Fog!!

Or

Blazing through the Maze!

AZ Center for Rural Health Conference
Flagstaff, AZ June 2024

THE UNIVERSITY OF ARIZONA
Arizona AHEC
Area Health Education Centers

Acknowledgements
The Response to GME - Amazing

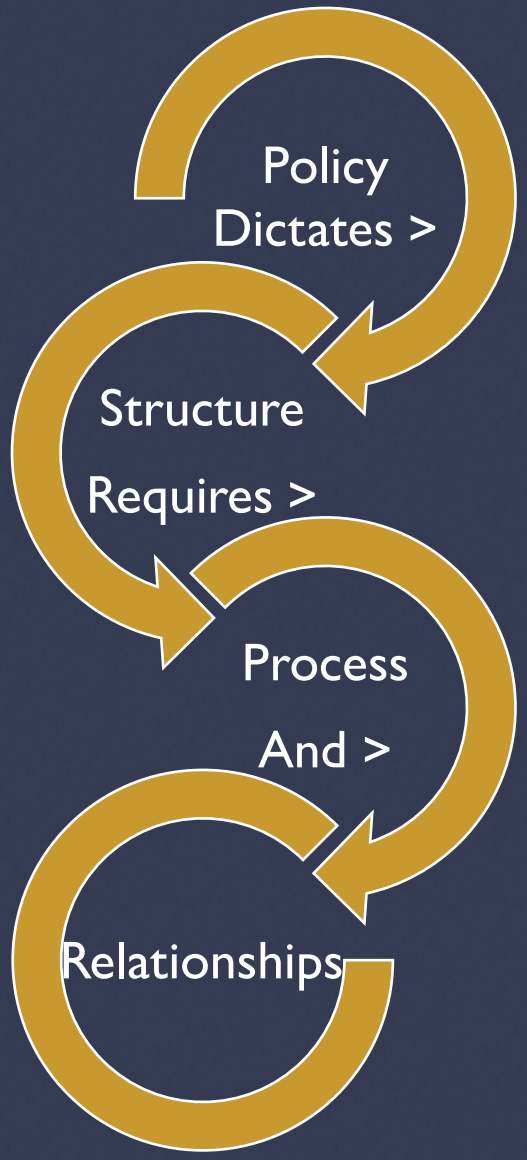
- State of Arizona
- University of Arizona Health Sciences
  - AHEC
  - CRH
  - Partners in Training
- AACHC, Az Hospital and Healthcare Association
  - FQHCs, RHCs, CAHs, Hospital Partners
- State Agencies – Medicaid / Primary Care
- University of North Carolina – HRSA RRPD and THC TA programs

Who is here + Who is not here but wishes they were (Zoom Participants)

- FQHCs*
  - With Federal Development Grants
  - With THC GME operational Grants
- RHCs*
  - With Federal Development Grants
  - With THC GME operational Grants
- Tribal Health Authorities
- IHS / VA Facilities
- Urban IPPS Hospitals*
- Rural Referral Centers*
- Urban non-IPPS Hospitals*
  - Psychiatric facilities*
- Rural Hospitals*
  - Sole Community Hospitals*
  - IPPS
- Medicare Dependent Hospitals*
- Critical Access Hospitals*
- State Agencies
- Health-related Associations
- Others?

*Each Medicare Provider Classification Listed here has different rules Governing GME payments

In this Presentation



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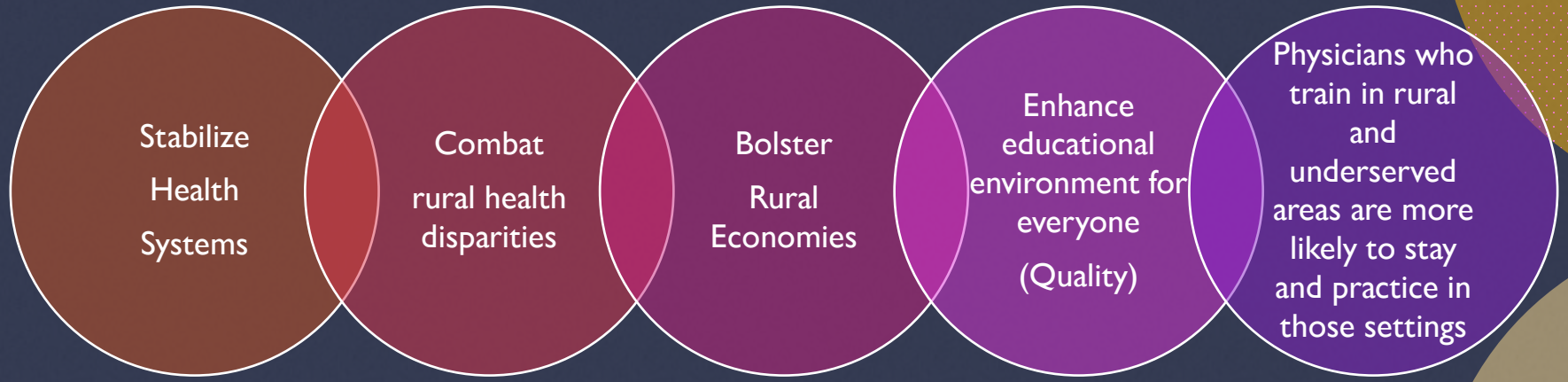
= GME $

Purposes of the Presentation

- To provide some focus to the very complex environment of Graduate Medical Education (GME) financing
- Partner selection considerations for sustainable training:
  - It all starts here financially
- Explain how classifications of Health Facilities / Providers Impact Partnering Opportunities – Link to Resources
- How to develop financing and operational support of Quality Physician Training
- ID resources to maximize, sustain or enhance GME
  - The Maze that is Medicare GME
  - What's happening with AZ Medicaid GME

Why develop Rural and Underserved Population GME Programs?



- 20% of Population*
- 2-year life expectancy gap
- Older, Sicker, Poorer

UNC Slide for Missouri GME program development * National Average

What is GME and Why AZ?

Why Arizona?
39% of PC Phys. Needs Met
42nd in active PCP/100k
31st in Total Phys/100k
Too few residency slots

Physician training post Medical School

- Osteopathic (DO)
- Allopathic (MD)

Undergraduate Students become Medical Students **(UME),** Obtain Medical Degrees, Become Residents **(aka GME),** Become Licensed, Become Board Eligible upon Residency completion, Become Board Certified in Specialty after National Boards.

- Touch opportunities
- Pathways planning
- What makes GME different?

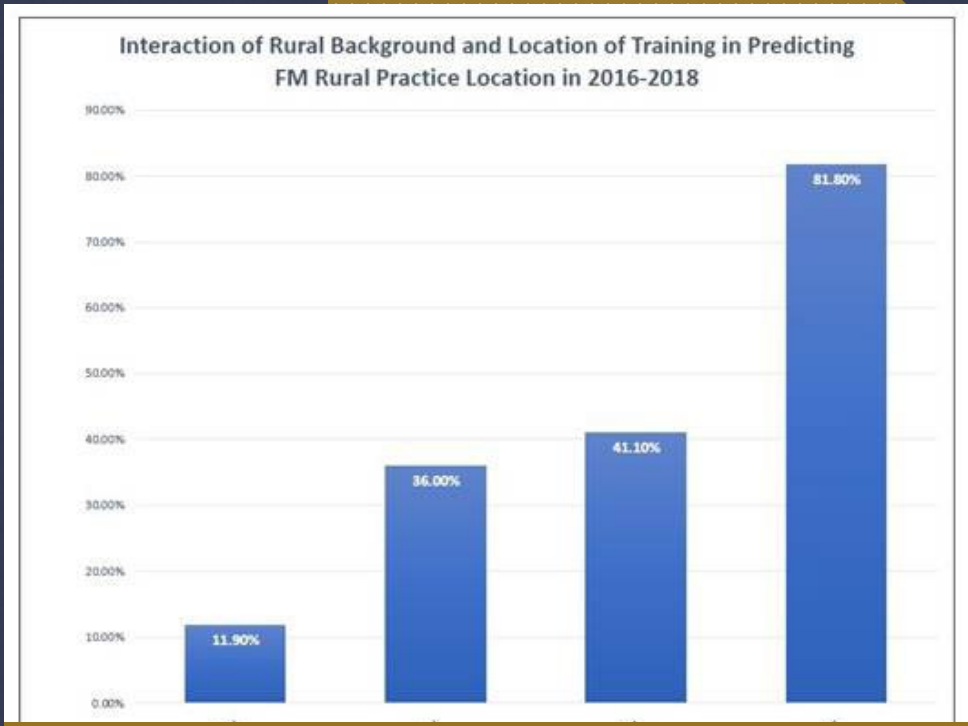
GME: Physician training programs are **uniquely** accredited and financed:

- ACGME-accredited Institutional Sponsor (SI)
- Each Program Accredited Independently within SI
- Clinical Training Partners Finance and Operate programs with GME payments and/or grants

How do you grow rural physicians?

Factors most associated with entering and maintaining rural practice

- Rural upbringing
- Positive clinical and educational experiences in rural settings in undergraduate medical education
- Targeted training for rural practice at post-graduate level
- Preparedness to be a rural community leader



Urban background and Urban Residency	11.9%
Rural Background and Urban Residency	36.0%
Urban Background and Rural Residency	41.1%
Both Background and Residency Rural	81.8%

Health Serv Res. 2024 Feb;59(1):e14168. doi: 10.1111/1475-6773.14168.

Value Proposition Example

GME Econ 101

Rural Community of 25,000

Demands Approximately 79,750 Primary Care visits per year (3.19 average)*

One primary care provider provides 2,000 patient visits per year requiring 40 PCPs *

Family Medicine Residency produces 4 residents a year and retains approximately 50% of graduates.

Program provides 20 graduates for the community over 10 years + 12 residents in training each year. Plus faculty who work in the program and also see patients.

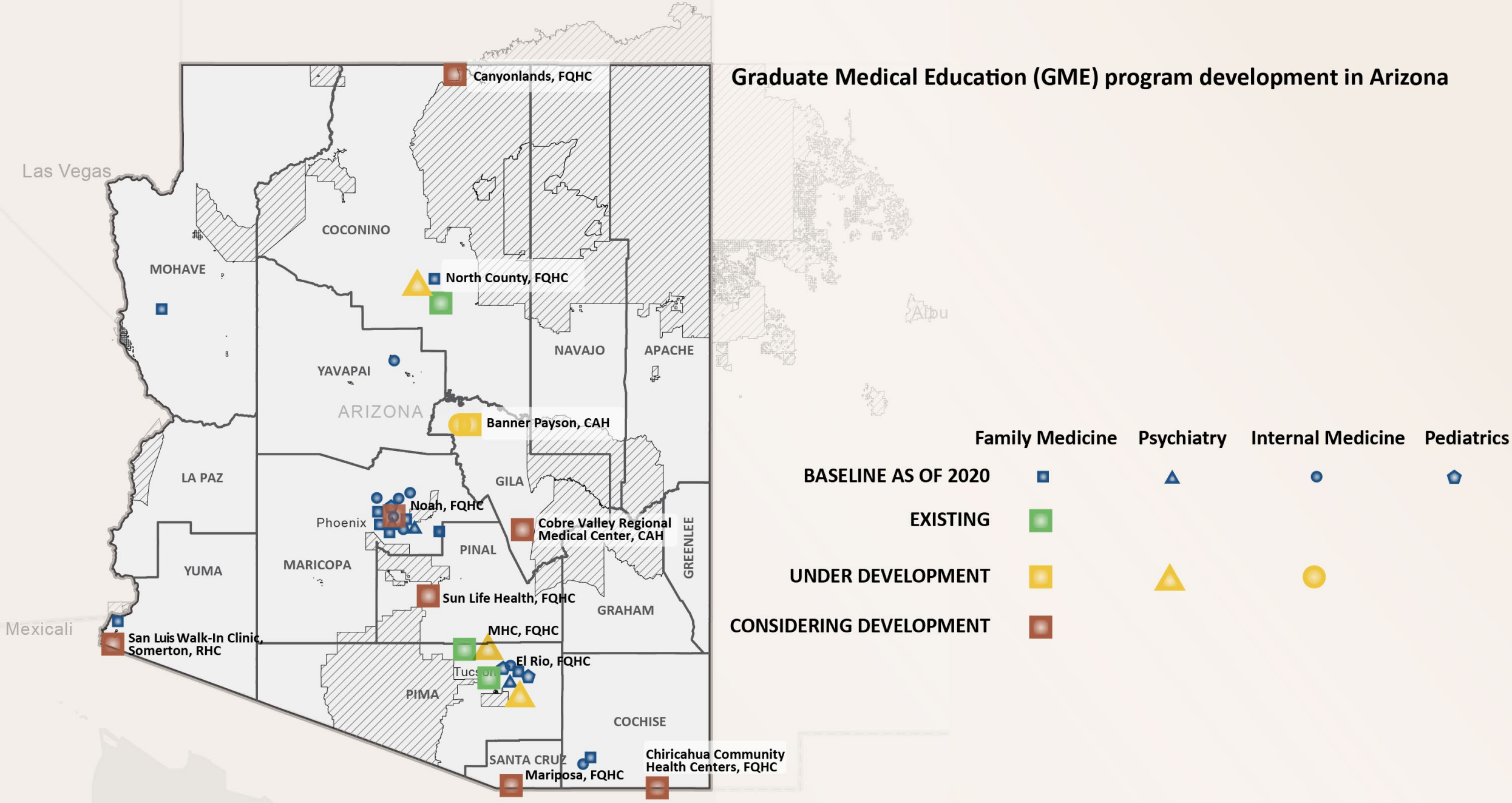
Program alone helps provide >80% of PC physician needs

- Can reduce the need for other specialists or they can fill voids if specialist leaves (i.e. endocrinologist, pediatrician, obstetrician)

Residency programs in rural areas export graduates to other rural areas improving supply

*Source: https://www.aafp.org/pubs/fpm/issues/2007/0400/p44.html#:~:text=Over%20a%20number%20of%20years,visits%20per%20patient%20per%20year.

Graduate Medical Education (GME) program development in Arizona



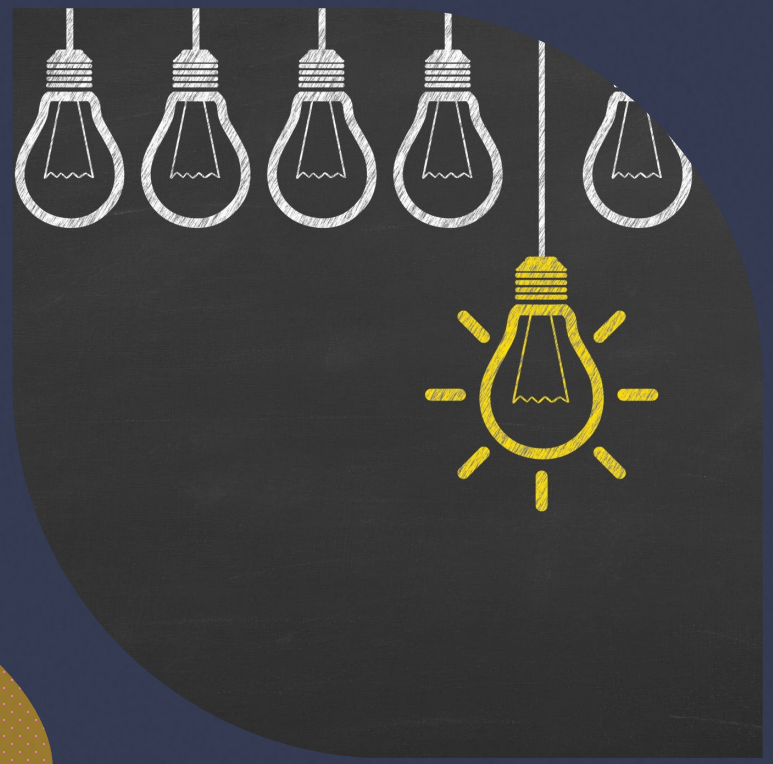
Don’t Be Overwhelmed - TA is Available!
Building Blocks - Progressive Development

- One Organization at a time
- One Community at a time
- One Partnership at a time
- One Proforma / Budget at a time
- One Program Accreditation at a time

What you don’t know, you soon will!

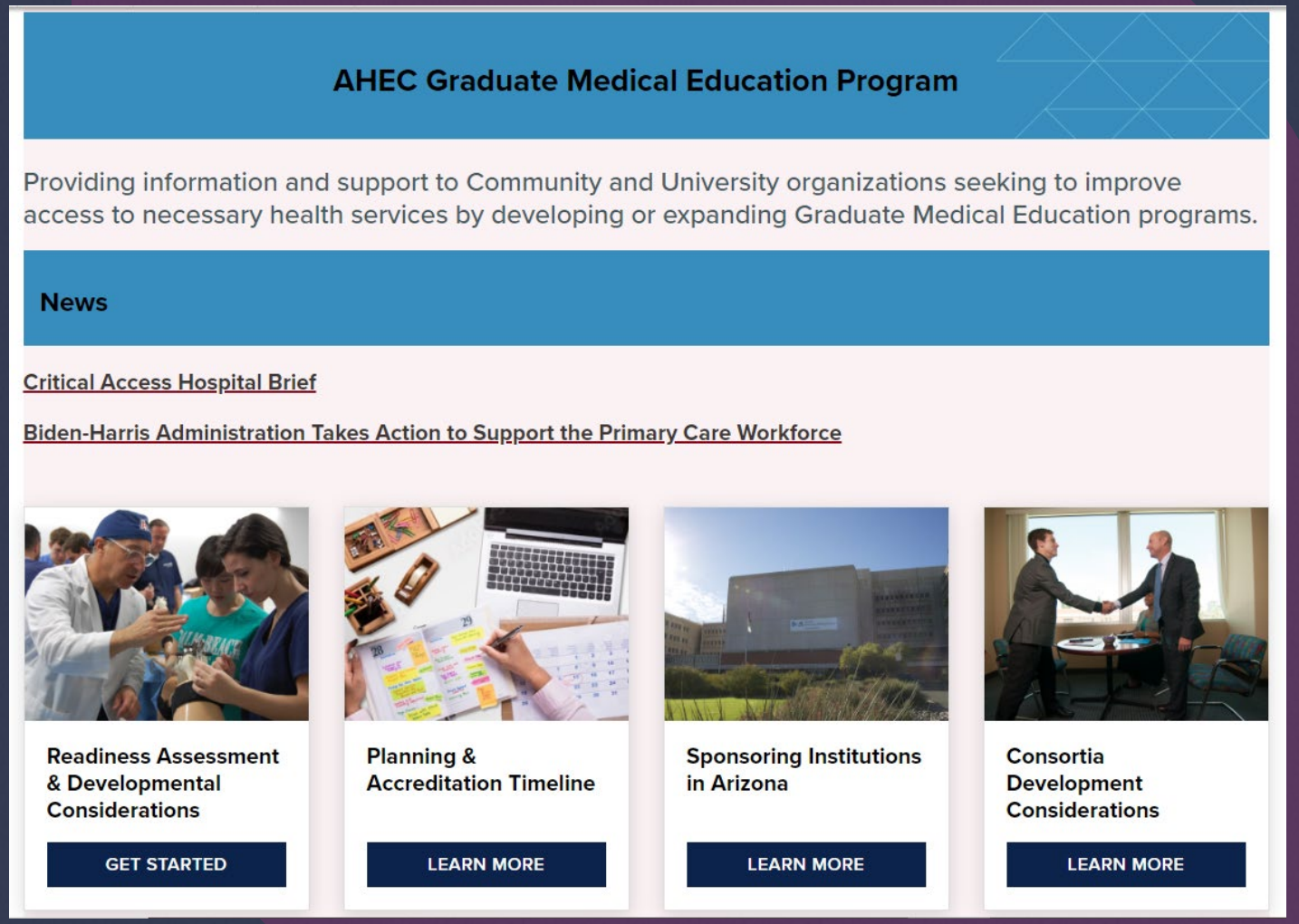
Resources for GME Development

HELP!!!



- Funding
  - HRSA – Rural Residency Planning and Development Grants
  - HRSA – Teaching Health Center Planning and Development Grants
  - **U of AZ, AzAHEC GME Planning and Development Funding**
  - Operational Revenue
  - State-based Foundations
  - Other?
- Technical Assistance
  - AzAHEC – Collaborative Financing
  - AzAHEC – Technical Assistance program (Ed and Charlie and AHEC/CRH Teams!!!)
    - One-line GME Development Toolkit under construction
    - **https://azahec.arizona.edu/ahec-graduate-medical-education-program**
  - **https://www.ruralgme.org/portal/toolbox/tools**
  - U of AZ - Center for Rural Health and AHEC programs
  - Teaching Hospitals Partners
  - Other Experienced FQHCs and RHCs
  - Trade Association Partners!

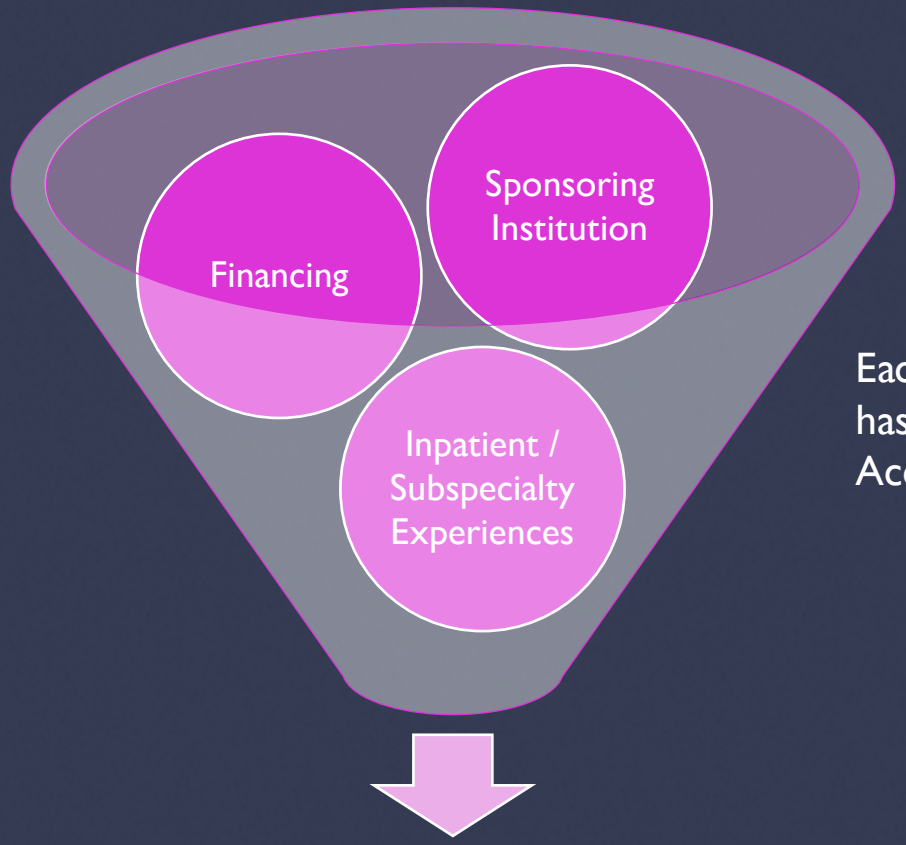
Future AHEC GME Program Webpage



Readiness Quick Check

- ACGME-accredited Sponsoring Institution (SI)?
- For THC: Hospital(s) or clinical sub-specialty partners identified?
- Governing Body endorsement of GME
- Staff endorsement of GME
- Do you have GME operational financing plans?
- Has a Program Director or Clinical Champion for GME development been identified in your program?
- A comprehensive Readiness Assessment is available from AHEC GME Staff (us). We can help you think it through

All GME Financing Occurs through Partnerships and Affiliations in Accredited Programs



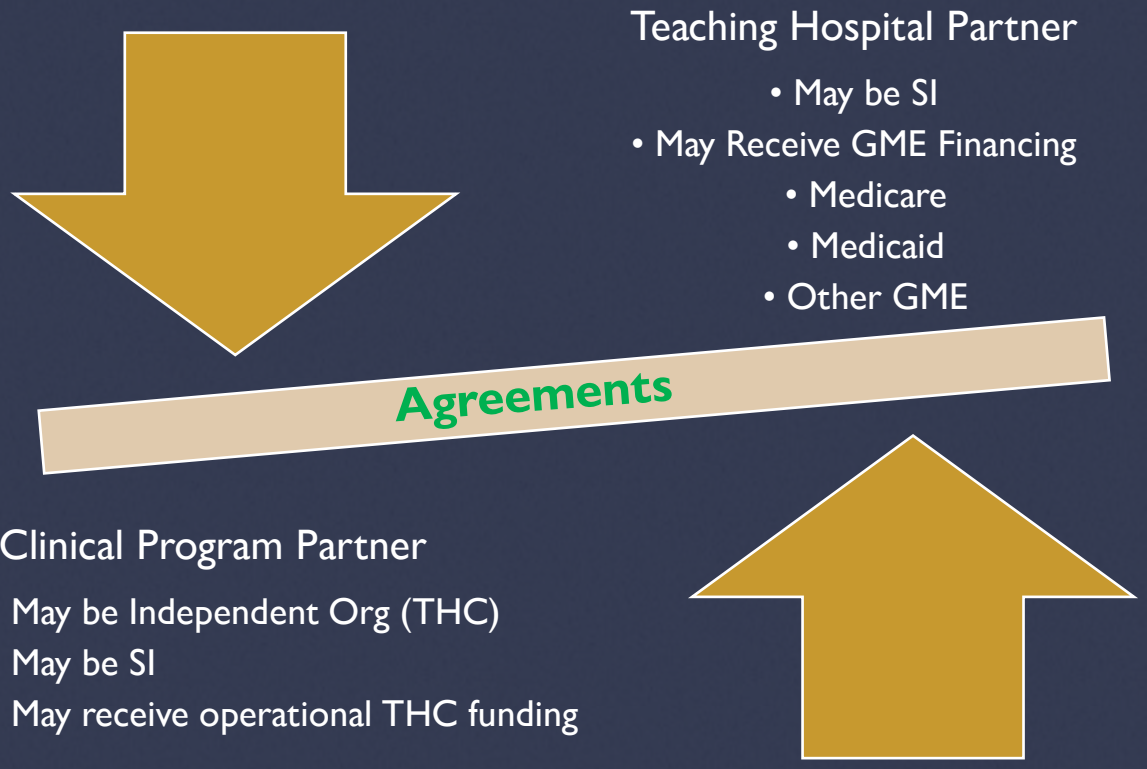
Each Medical Specialty has unique ACGME Accreditation Criteria

Internal / External Partnerships Required

- Traditional GME is accomplished internally between the Host Teaching Hospital and its Clinical Departments or University Clinical Departments
- **<u>Almost all new program development requires unrelated affiliated partners</u>**
  - Assure Clinical Scope of Services for Accreditation
  - Sustainable Program Financing – Hospital Medicare and Medicaid Payments can cover 100% of costs
  - THC funding doesn't cover 100% of typical costs
  - Urban / Rural Partnerships / Affiliations

GME Program Financing Requires:

- **ACGME-accredited Sponsoring Institution (SI)**
- **Program-Specific Application and Accreditation**
- **Clinical Training Partners that Finance and Operate programs with GME payments and / or grants**



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
- Rational Training Environment (Geography, Capacity, Balance, Collegiality or……
- Build it yourself
- **Understand Financial Opportunity – Partner GME financing eligibility Issues**

Sponsoring Institution (SI) Considerations

SI is an ACGME Accreditation Status

Not a Legal Entity

- Has Governing Board
- A Function of an Org.

Does Not Receive Medicare, Medicaid Payments or Grant Funds Directly

- Internal Budget Item
- External Contract Matter

Required to approve program application development and submission

May or may not be a HC Provider

Any organization can have ACGME SI accreditation if it meets the standard of an SI

DIO

GMEC

Fiscal Attestation

HR Infrastructure

Independent Health Org. – Hierarchy

Governing Board

Management

SI

Program(s)

Has PLAs

Partnerships / Affiliation Agreements

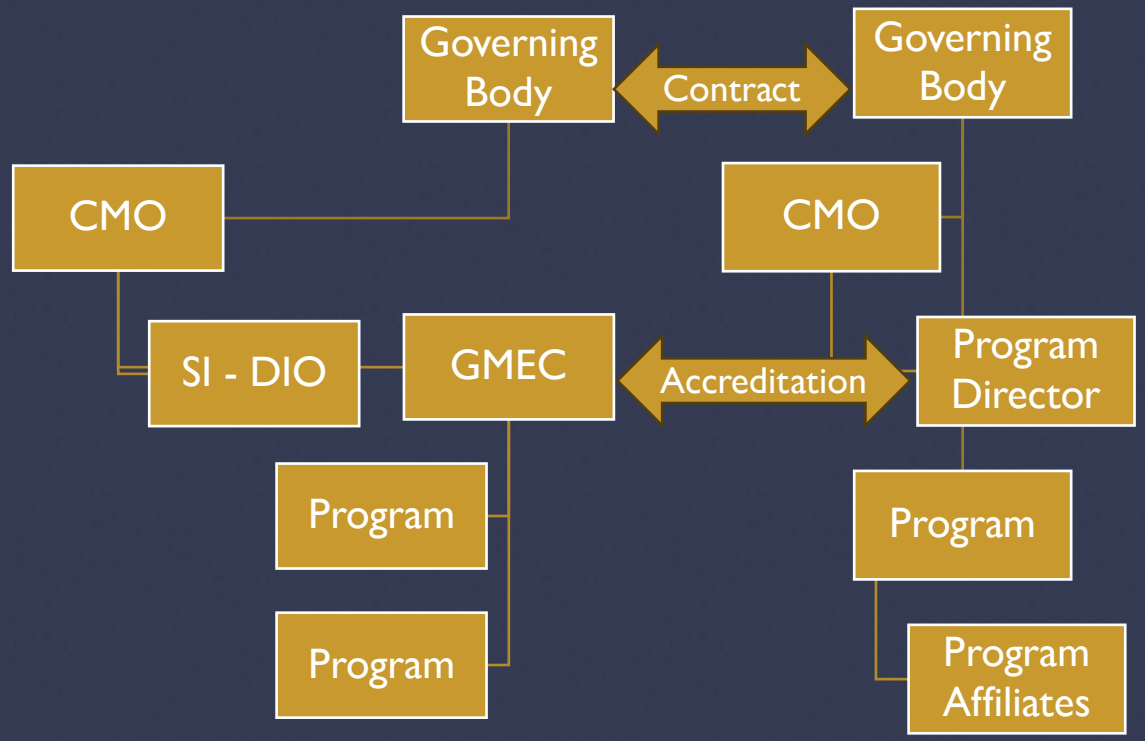
Contracts with an Organization with SI Status to develop Program

Consortium – Collaborative

Multiple Partners Create New Entity Or Repurpose Existing System to Facilitate Residency Development and Program Sponsorship

Contact us for List of SI's in AZ and Descriptions of different types of Agreements – Soon to be on-line on AHEC and CRH Websites

Relationship Structures: Independent Program Gets a Partner



Independent Program

Partner Program Contract

What are the Benefits of Partnering with an Existing SI / GME Program?

CMO
Chief Medical Officer
SI
Sponsoring Institution
DIO
Designated Inst. Official
GMEC
Graduate Medical Education Committee

Relationship Structures
One Type of Consortium

What are the benefits of Developing and Independent Consortium?

Independent SI Consortium

SI comprised of Partners, that "own" the operation of the SI and accreditation of the Programs

Partners "own" clinical services and day to day operation of the training program – Independent Orgs come together to support GME

Partner GME revenues support the operation of the SI.

Each accredited program is unique and financially viable. Local program partners finance programs

SI or partners can employ residents

KNOW YOUR PARTNERS!

- **Hospitals are the primary source of GME financing - Period**
  - Medicare
  - Medicaid
  - Some states have variations FQHC / RHC payments in Medicaid
    - AZ has regs not yet approved by CMS
    - Hospital GME status is critical even if there is THC grant funds
- **Hospitals MUST report Resident FTE if >1 Resident**
- **https://www.ruralgme.org/portal/hospital-analyzer**
  - Sign up on RuralGME.org
  - Find Hospital Analyzer Page – Example to follow
- **Hospitals may claim resident time spent at FQHC/RHC/CAH!!!**
  - **HRSA THC grant funds Impact**

Choosing Partners / Fit

- Shared Mission
  - Strategies to Increase Access to Health Services
- Competition / Duplication / Collaboration Issues
  - Historical Patient Markets
  - Complementary Clinical Mix
- Shared Clinical Locations / Resources
- Cost and Revenue Agreements
- Shared Decision Making in GME
  - SI / Grad. Med. Ed. Comm. membership
- Sustainable Infrastructure / Capacity
- Quality and Outcomes Focused

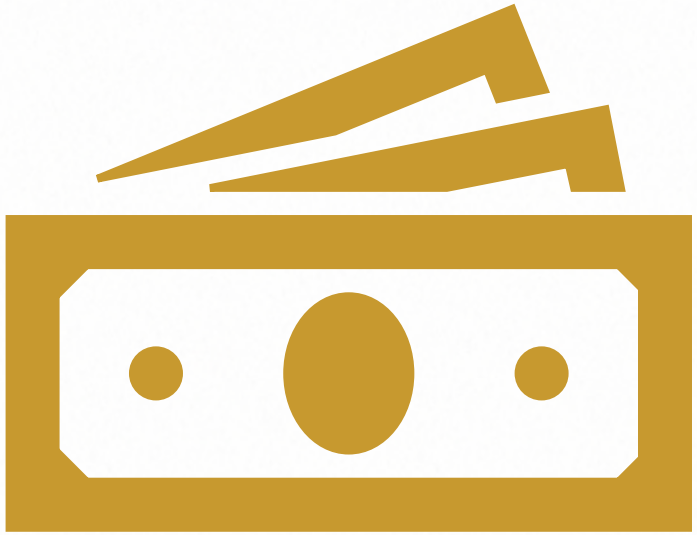
Transparency

Trust and Verify (Contracts)

GME Payments /Revenues

Sustainable Programs

- Medicare
- Medicaid
- Teaching Health Center Grants
- Operational Financing
- Other?



Medicare Opportunities

Medicare Certified hospitals have different classifications

Each classification has a different relationship with GME payment rules

Hospital Classifications:

https://www.ruralgme.org/portal/hospital-analyzer

- To find the GME payment status of hospital partners, search specific hospitals here
- For GME definitions of hospital type, click on the Glossary of the opening page of the Hospital Analyzer

BOULDER CITY HOSPITAL

(BOULDER CITY, NV: CCN 291309)

Produced: September 2023

This information sheet provides a high-level overview of various considerations for GME at this hospital. It is based on secondary information which may not be currently accurate. **Potential GME programs are urged to carefully review and confirm their current details and eligibility.** Additionally, developing rural programs should conduct an analysis of every potential training location for its curriculum using the Am I Rural? tool. Resources listed below provide additional information.

This hospital

- is located in a CMS designated **Metro** (defined by OMB's CBSA standards (2020)). Only resident training in rural places will count towards the requirement for RTP funding of at least 50 percent in rural places.
- is classified **N/A** by CMS. This may affect the hospital's ability to add IME cap depending on its category described below.
- is considered **Not Rural** according to the Federal Office of Rural Health Policy. This affects eligibility for rural health grant programs but not Medicare GME funding.

A hospital may fall into multiple categories below - e.g. be both an RRC and a SCH or a Category A in a Lugar County.

Hospital in category?	**Category**	**Implications for GME.** Further details are provided in on the Rural GME Analyzer website.
Yes	Critical Access Hospital (CAH)	NOT an IPPS hospital. Time residents spend in a CAH can be claimed by a residency partner IPPS hospital (if it meets nonprovider setting requirements) which often is more financially advantageous than direct expense claims by the CAH. The status of the partner IPPS hospital will matter when considering that option. Click for more detail.
	Sole Comunity Hospital (SCH)	A special type of IPPS hospital. Special rules apply that limit IME payments. Click for more detail.
	Medicare Dependent Hospital (MDH)	A special type of IPPS hospital. Special rules apply that limit IME payments. Click for more detail.
	Rural Comunity Hospital (RCH) Demonstration	A special type of IPPS hospital. Special rules apply that limit IME payments. Click for more detail.
	Rural Referral Center (RRC)	A special type of IPPS hospital. Special rules apply that allow new GME programs to qualify for new Medicare GME payments. Click for more detail.
	IPPS hospital that is a Never Claimer	There is no evidence this hospital ever claimed GME expenses on a Medicare cost report. Thus, likely a hospital. A GME-naïve hospital can get Medicare GME payments when the hospital first starts resident rotations. Click for more detail.
	Category A	This IPPS Hospital has a low cap and may also have a low Per Resident Amount (PRA) suppressing their DGME payments. Category A and B hospitals may be able to reset their PRA and could add to that cap with a new GME program. Click for more detail.
	Category B	
	Established Teaching Hospital	This hospital has a cap high enough that it is not eligible for Category A or B reset opportunity. Their cap can't generally be increased unless it has a CMS classification and/or location or participates in a new RTP residency. Click for more detail.
	Indian Health Service (IHS) Hospital	Special considerations apply for IHS hospitals. Click for more detail.
	Lugar County	Hospitals in Lugar counties (all are classified as locations) have the option of reclassifying as to get a better wage rate. However, this can limit GME funding qualification. Click for more detail.

For more detail on provisions, visit https://portal.ruralgme.org/hospital-analyzer

GME Hospital Types

- IPPS – Most hospitals – DRG paid – GME Eligible
  - IPPS Excluded hospitals – psych, rehab, children's LTC, CAH, Cancer, Hospital Units with these classifications
  - Eligible for GME payments
    - IME
    - DGME
  - All have CAPS
  - RTP has CAP exception – also Dental, Podiatry, Pharmacy
- CAHs – Non-Provider for GME purposes
  - Not IPPS –
    - Direct Cost of residency plus 1% paid based on Medicare Mix
    - Since 2019, most IPPS hospitals can claim CAH resident FTE
- Sole Community Hospitals / Medicare Dependent Hospitals
  - Type of IPPS with different GME payment rules
  - DGME possible but IME only for Medicare Advantage Patient %

GME = IME + DGME

IME = Indirect Medical Education Payments – Formula approved by Congress

DGME = Direct GME -Cost of Residents / Faculty in Per Resident Amount (PRA)

GME Hospital Types – More!

There are others

Contact your MAC to verify GME status!

- RRCs
  - Type of IPPS
  - Most in Urban areas and have Rural Classification
  - Very popular
    - 340B
    - Wage Index
    - 30% GME CAP Bump with conversion to Rural
    - Plus can add IME CAP with "new separately accredited program"
    - Can get DGME increase with RTP even if not "new program"
- IPPS "Never Claimer" aka "GME Naïve Hospitals"
  - New GME Program Rules Apply
    - Setting DGME PRA in first year
    - Must start claiming residents when >1 FTE
    - 5 Year CAP building
    - Potentially great partners in terms of Program Development

HCRIS Report Section

All Hospital GME Medicare payments can be found on HCRIS reports:
RuralGME.org – Toolbox – Search for HCRIS – Hospital Type and Data Look-Up File
Search by State and Hospital - Contains IME and DGME data

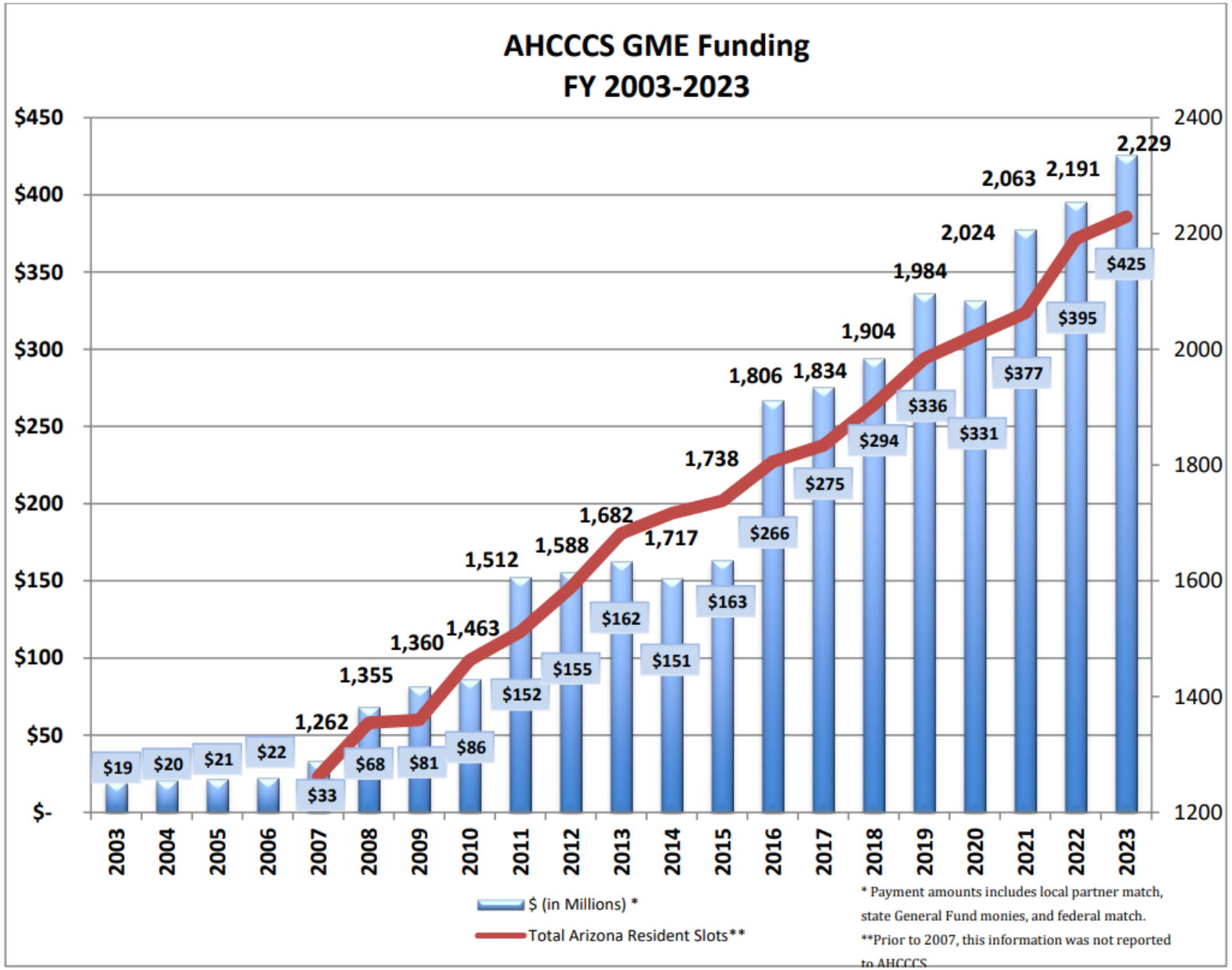
Provider Number	State	Name	URGEO	URSPA	LUGAR	Section 401 Hospital	Resident to Bed Ratio	Beds	Calculated Residents (Beds x IRB)	Average Daily Census	Provider type (Impact 2024)	Provider type (Impact 2022) if differs from 2024	Graham Center FY21 calc DME$/FTE resident	Graham Center FY21 calc IME$/FTE resident	Graham Center FY21 DME FTE cap	Graham Center FY21 DME FTE claimed
010001	Alabama	Southeast Health Medical Center	OURBAN	RURAL		Y	0.1233	326	40.2	271	RRC				39.0.	
010005	Alabama	Marshall Medical Centers South Campus	RURAL	RURAL			0	192	0	95	RRC					
010006	Alabama	North Alabama Medical Center	OURBAN	RURAL		Y	0.1708	223	38.1	156	RRC				.	36.0
010007	Alabama	Mizell Memorial Hospital	RURAL	RURAL			0	45	0	16	MDH					
010008	Alabama	Crenshaw Community Hospital	RURAL	RURAL			0	29	0	5	IPPS					
010011	Alabama	St Vincent's East	LURBAN	LURBAN			0.0668	275	18.4	215	IPPS		$ 61,072	$ 99,439	29.6	27.0
010012	Alabama	Dekalb Regional Medical Center	RURAL	RURAL			0	97	0	26	SCH					
010016	Alabama	Shelby Baptist Medical Center	LURBAN	LURBAN			0	212	0	116	IPPS					
010018	Alabama	Uab Callahan Eye Hospital Authority	LURBAN	LURBAN			0.3883	6	2.3	1	IPPS		$ 40,149	$ 21,646	9.3	6.2
010019	Alabama	Helen Keller Memorial Hospital	OURBAN	OURBAN			0	172	0	74	IPPS					
010021	Alabama	Dale Medical Center	RURAL	RURAL			0	77	0	23	IPPS					
010022	Alabama	Floyd Cherokee Medical Center	RURAL	OURBAN	LUGAR		0	45	0	12	IPPS					
010023	Alabama	Baptist Medical Center South	OURBAN	OURBAN			0.13	311	40.4	264	IPPS		$ 39,331	$ 119,404	42.3	40.7
010024	Alabama	Jackson Hospital & Clinic Inc	OURBAN	RURAL		Y	0	278	0	183	RRC					
010029	Alabama	East Alabama Medical Center	OURBAN	RURAL		Y	0.0316	311	9.8	205	SCH/RRC	RRC			.	.
010033	Alabama	University Of Alabama Hospital	LURBAN	LURBAN			0.2958	1129	334.0	972	IPPS		$ 30,434	$ 121,711	366.5	631.2
010034	Alabama	Community Hospital Inc	OURBAN	OURBAN			0	37	0	6	IPPS					
010035	Alabama	Cullman Regional Medical Center	RURAL	RURAL			0	137	0	92	SCH/RRC					

Medicaid Funding Opportunities

- CMS typically limits Medicaid GME funding to hospitals
- Funding is limited to the Medicaid utilization
  - If a hospital has 30% Medicaid utilization, then no more than 30% of the funding should come from Medicaid
- Medicaid may pay for both direct and indirect GME costs
- In Arizona, the federal government pays approximately 2/3 of the cost of Medicaid GME
  - The remainder can either be paid for by the state General Fund or partnerships with political subdivisions. Political subdivisions include cities, counties, hospitals districts, tribal governments, and Arizona public universities

Medicaid Funding History

- Historically there have been few monies appropriated in the state budget for GME
- During the Great Recession, the government cut all funding for GME but allowed hospitals to partner with political subdivisions in order to grow their GME programs
  - While it took some time, all but one hospital partners with a political subdivision for GME funding
- In 2020, the state once again began appropriating money, but only for new/expanded residencies/fellowships after July 1, 2020
  - Approximately $15.7 million is appropriated for “rural” hospitals and $12.5 million for “urban” hospitals
  - Currently not all rural funding is being used for rural hospitals


AHCCCS GME Funding
FY 2003-2023
$450
$400
$350
$300
$250
$200
$150
$100
$50
$-
2400
2200
2000
1800
1600
1400
1200
$19
$20
$21
$22
$33
$68
$81
$86
$152
$155
$162
$151
$163
$266
$275
$294
$336
$331
$377
$395
$425
1,262
1,355
1,360
1,463
1,512
1,588
1,682
1,717
1,738
1,806
1,834
1,904
1,984
2,024
2,063
2,191
2,229
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
$ (in Millions) *
Total Arizona Resident Slots**
* Payment amounts includes local partner match, state General Fund monies, and federal match.
**Prior to 2007, this information was not reported to AHCCCS

2024 GME By the Numbers

- $406 million payments where political subdivision provides match
  - 32 hospitals
  - 1,897 residents/fellows
  - Indirect payments range from $133K-$217K per resident
- An additional $16 million where the state General Fund provides the match
  - 21 rural residents/fellows
  - Additional urban residents/fellows
  - Rural Hospital Medicaid Payments
    - IME + GME Range = $164K-$205K
    - Average = $187K
    - No Cap

Revenue and Expense Building Blocks (Budgets, Proforma, PnL)

- Size of Program
  - 2-2-2
  - 4-4-4
- Block Rotation Schedule Typically 12-13 Blocks per Year
  - # of periods and % of Rotations in Hospital 1
  - # of periods and % of Rotations in Hospital 2 (if applicable)
  - # of periods and % of Time in PC Setting
  - # and % Electives (locations)
  - Determines resident FTE for claiming Medicare and Medicaid payments
  - Hospitals can claim time spent in PC settings (FQHC, RHC) and CAHs
  - THC operating Grant considerations
- Block Rotations Determine Most Revenues

Revenue Look

Allocation of Resident FTE example	For each resident year			
	R1	R2	R3	Total
Residents	4.00	4.00	4.00	12.00
See FTE claims details tab:				
res FTEs claimed by hospital #1	0.89	0.74	0.74	2.37
res FTEs claimed by hospital #2	2.62	2.95	2.95	8.52
res FTEs claimed by hospital #3	0.49	0.00	0.00	0.49
res FTEs not paid for (e.g. far away electives)	0.00	0.31	0.31	0.62

Estimating Revenues

- Medicare – Count FTE to Determine
  - IME
    - Obtain from hospital partner(s) or HCRIS
  - DGME – PRA
    - For new Program PRA is established in first year of training in Hospital
    - If Existing programs use hospital PRA #
    - Regional PRA can be used if PRA unknown
- Medicaid - Same Principles
  - IME
  - DGME
- HRSA THC Operating
- Other Revenue

The impact of THC funds relative to hospital GME payments is under review

Estimating Medicare and Medicaid $

GME collections					
Medicare GME income for partners		per FTE			
hospital #1 Medicare GME (					
DGME per FTE		36,242			
IME per FTE		24,390			
res FTEs claimed by hospital #1	2.37	60,632	143,651		
hospital #2 Medicare GME					
DGME per FTE		49,653			
IME per FTE		90,713			
res FTEs claimed by hospital #2	8.52	140,367	1,196,358		
TOTAL				1,340,010	total Medicare GME collections by 2 partner hospitals
				111,667	per FTE resident

These are examples only.
Don't try this at home.

Estimating Costs

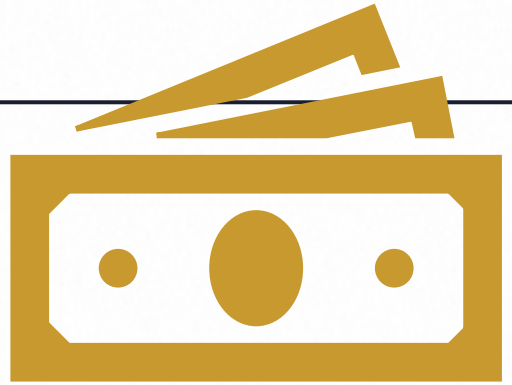
90+ % of Training Costs

Resident Salaries
- Resident Fringe

Clinical Support – Some FTE determined by Accreditation Standards
- Program Director (FTE)
- Associate Program Director
- Core Faculty
- Other Faculty
- Program Coordinator
- Other Direct Residency Support Staff
- Staff Fringe

SI Costs
-Designated Institutional Official
-SI Institutional Coordinator
-Other
- Educational Support
- Site Visits
- Operating Expenses
- ACGME Fees

NEW!!



Other
- Resident Recruitment
- Away Rotation Travel
- Licenses, Subs and Dues
- Certifications
- Computers / Phones / Tech
- Accreditation Fees
- Administrative Supplies
- Orientation / Graduation / Food
- Conferences Real and Virtual
- For THC only funding –
- Hospital Partner Expenses
- Supplemental Malpractice if needed
- Indirect Rate?

Arguments for not Including Visit Revenues and Expenses in Budget

- Resident and Faculty Salaries and Fringe / Admin Expenses Covered
  - Reduces per visit costs – Payments Same
- GME payments to cover training costs
- Resident / Attending Visit Revenue goes to Operations
- Residency Sustainability not Volume Dependent
  - Understand that the first year any possibly second are an investment in the future
- Others?

Happy Developing!!!

Questions!!!!

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