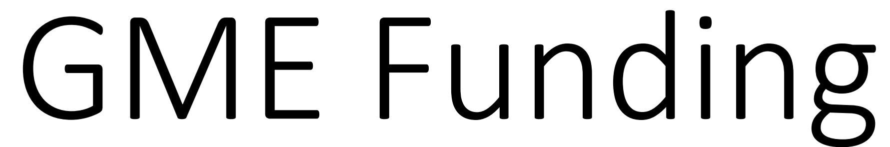


Suzanne Allen, MD, MPH

7th WWAMI GME Summit

History

- Medicare
- Medicaid
- Veteran’s Administration
- Children’s Hospitals
- Teaching Health Centers
- Consolidated Appropriation Act 2021
- State support
- Health System

Medicare

- Money goes to the hospitals, not residency programs
- Dependent on per resident amount (PRA), %Medicare, geography, cap
- Direct GME funding – resident salaries, benefits
- Indirect GME funding – add on to offset cost of training
- 1997 Balanced Budget Act
- Redistribution of unused caps
- Hospitals with no caps

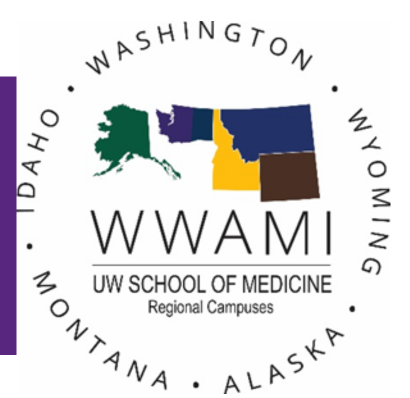
Medicaid

- In 2018, $5.58 billion support for GME training
- Differs by state
- 43 states (including Washington DC) reported Medicaid GME in 2018 AAMC survey
- Some only direct GME some direct and indirect GME
- Washington, Montana and Idaho have Medicaid GME
- Wyoming and Alaska do not have Medicaid GME

Veteran’s Administration

- One of largest providers of GME training in country
- Supports GME by working with affiliates
- Covers direct and indirect
- Expansion of GME positions by 1500 between 2014 – 2019
- Funding only applies for educational activities within the VA

Children's Hospitals



- HRSA funded
- Yearly appropriation/application
- Separately accredited Children's Hospital
- Direct and indirect funding
- Covers 43% of general pediatric training programs and 55% of sub-specialty residents and fellows

- https://bhw.hrsa.gov/funding/apply-grant/childrens-hospitals-graduate-medical-education

Teaching Health Centers

- Section 5508 of ACA, “Increasing Teaching Capacity”
- Includes: FQHC, community mental health clinic, rural health clinic, IHS or tribal health centers, Title X clinics
- Funds go directly to the program for outpatient training in rural and underserved areas
- Began in 2011, 1730 graduates thus far
- 960 residents in 72 programs in 2022-2023 in FM, IM, Peds, IM/Peds, OB/GYN, Psychiatry, General Dentistry, Pediatric Dentistry, Geriatrics
- https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education

Consolidated Appropriations Act 2021

- Section 126 – Distribution of additional residency positions
- Section 127 – Promoting rural hospital GME funding opportunity
- Section 131- Adjustment of per resident amount (direct GME) and low FTE caps (direct and indirect GME) for certain hospitals

Section 126

- Makes available an additional 1,000 FTE resident cap slots phased in at a rate of no more than 200 slots per year beginning with an allocation for 2023
- Deadline was March 31, 2022 to apply for first 200 slots. Will have 4 more “rounds” in the coming years

Section 126

- The additional cap slots will be distributed to hospitals that are included in at least one of the following four categories (with at least 10% of slots going to each category over 5 years):
  - Hospitals located in rural areas or that are treated as being in a rural area
  - Hospitals that are training residents over their cap amount.
  - Hospitals located in the 35 states (listed in the rule) with new medical schools or additional locations and branches of existing campuses.
  - Hospitals that train residents in a program where at least 50 percent of all residents' training time occurs at site(s) physically located in a geographic Health Professional Shortage Area(s) (HPSA).
  - Mental health geographic HPSAs can only be used for psychiatric programs.

Section 126

- Additionally, HPSA scores will be used to prioritize all applications, not just category 4. A hospital must meet the "50 percent criterion" such that at least 50 percent of the training time of the program requesting the increased slots must occur at facilities physically located in a geographic or population HPSA (or 5 percent if 45 percent of the training time occurs at an IHS facility/facilities).

Section 127

- New definition and language aligned with the ACGME process for preaccreditation endorsement as a "rural track program (RTP)" for tracks beginning in the first cost-reporting period after 10-1-2022
- New opportunity to create "not separately accredited" programs in multiple specialties
- New opportunity for urban hospitals to expand an already established, and separately accredited, RTT (previous terminology) that they sponsor or in which they participate, now a "RTP," to additional rural sites; a rural hospital can only do so with another "RTP" of an urban program
- No 3-year rolling average during the 5-year cap-building period

Section 127

- New definition - a ‘rural track program’ is a program, whether separately accredited or not, where residents spend time in both urban and rural settings and the time spent training in a rural place is > 50% of the total training time for residents in the program (or track) as a whole.

Section 131

- Allows a per resident amount (PRA) reset for some hospitals with low (including zero) PRAs.
- Allows certain hospitals with very low historic caps to add cap positions for new residencies.
- For hospitals with no prior claims of GME training, no PRA will be set or cap clock started until the first cost report year when resident FTEs >= 1.0.

Section 131

- Category A: Hospitals that became teaching hospitals before Oct 1997, with PRA and cap based on <=1.0 FTE (either or both of DGME and IME).
- Category B: Hospitals that became teaching hospitals after Oct 1997 through Jan 2021, with PRA and cap based on <=3.0 FTE (either or both of DGME and IME).
- “GME naïve”: Hospitals that have never had GME trainees
- “Never claimers”: Hospitals that HAVE had GME trainees but never claimed them on their CMS cost reports.

State Support

- Varies by State
- WWAMI state examples

Health System

- Sponsoring institution
- Clinical revenue
- GME program impact
- Quality of care
- Recruitment

Resources

- Rural Health Information Hub – https://www.ruralhealthinfo.org/
- Rural GME – https://www.ruralgme.org/
- RTT Collaborative – https://rttcollaborative.net/