Graduate Medical Education in Wisconsin
Options for GME Consortia
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Webinar

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Webinar Sponsor

• Presented Under the AHW Graduate Medical Education Development in Central and Northern Wisconsin Grant: Grant Awardee, The Medical College of Wisconsin
• WI Collaborative for Rural Graduate Medical Education (WCRGME)
• Rural Wisconsin Health Cooperative: Grant Manager
The Purpose of this Webinar

• In recent years, multiple meeting, discussions and other efforts have occurred to advance the cause of expanding graduate medical education (GME) in Central and Northern Wisconsin
• Progress has been made, but more is needed
• The option of multiple stakeholders coming together in some form of a collaborative or consortium continues as an option to explore
• This webinar explores three possible options for the structure of a new consortium/collaborative
• This is a discussion and there is no advocacy for any of the options

TOPICS COVERED

• Quick Summary of Important Medicare Funding Considerations
• GME Consortia: high level overview
• Three potential Consortium/Collaborative models
  – Add new GME Programs under Medical College of Wisconsin Affiliated Hospitals (MCWAH) as Sponsoring Institution, with the new Northern and Central WI hospitals and health systems joining MCWAH
  – Create a new Norther and Central WI GME Consortium Entity as the Sponsoring Institution
  – Multiple Sponsoring Institutions, with the creation of a new WI GME Collaborative
• Medicare GME Reimbursement Development
The General Funding Components of GME Remain the Same, No Matter the Form or Purpose of the Consortium

- Medicare DGME/IME Reimbursement, paid to teaching hospitals – some Medicaid (maybe) little if any private insurance payment
- Clinical services revenue generated at the clinical teaching site, paid to the site operator/provider billing entity
  - Fee for service revenue from Medicare, Medicaid, private insurance/managed care
  - Medicare Physician at Teaching Hospitals (PATH) payment rules apply to services involving residents
- Other Sources
  - State grants, can be paid to a variety of participants
  - Educational Institution Support: Colleges of Medicine or Universities can be conduits to directed funding – Beware Community Support
  - Private donations – Beware Community Support
  - Federal Teaching Grants – Teaching Health Center Funding

New Teaching Hospitals

- Hospitals which do not historically participate in GME – GME Naïve - can become Teaching Hospitals by having residents on duty at the hospital
- “Teaching Hospital” is not a requested status, it is a result: if residents are regularly present in the hospital, CMS rules automatically establish PRA and FTE Cap
- PRA determined in first or second year that residents are present
- FTE Cap now based on 5 year period: see 77 F.R.53416, August 31, 2012
- Rural training track limit for urban hospitals, and new program additional FTE cap for rural hospitals, now determined on a 5 year period also: see 81 F.R. 57028, August 22, 2016
New Teaching Hospitals

• Traps to avoid - PRA
  – Have residents been in the hospital on an informal basis in past years? Has that set your PRA? The absence of any prior Medicare DGME/IME payments may not matter
  – If no direct medical education costs in the PRA determination year, the PRA can be $0.00 – zero, meaning that there will be no DGME payments

• Traps to avoid – FTE cap
  – Have any “new program” residents ever rotated to your hospital? If so, did that trigger your FTE Cap? If new program residents have been present, the 3/5 year cap determination period may have already started or even ended
  – A “new program” is a program that began and was newly accredited after 1995 (the year the FTE cap idea began), and is now defined by CMS rule. Only “new program” residents can build a cap, and the presence of new program residents at a hospital without an FTE cap will trigger the FTE Cap determination
RURAL TRACK TRAINING PROGRAM

- Medicare GME reimbursement recognizes “rural track training” (RTT) programs and provides additional/alternate funding to urban teaching hospitals
  - Urban hospital receives new “rural track FTE limit” that allows new and additional Medicare GME funding: DGME and IME (no separate IME for SCH, CMS says it is in the hospital-specific rate)
  - Rural hospitals can always “build cap”
  - Residents must spend at least 50% of time training in rural area
- ACGME does not specifically accredit rural training tracks, but it includes the idea of accrediting alternative training tracks, which can accommodate a structure that matches the Medicare requirements
  - Limited number of existing RTTs, but continued interest due to rural physician shortage

Community Support and Redistribution

- **Community support.** If the community has undertaken to bear the direct costs of medical education through community support, the costs are not considered GME costs to the hospital for purposes of Medicare payment.
- **Redistribution of costs.** The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered GME costs to the hospital for purposes of Medicare payment.
- A hospital must continuously **incur costs of direct GME** of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents.
  - 42 CFR 413.81
Community Support and Redistribution

• “Whatever vagueness may be found in the community support language that precedes it, the anti-redistribution clause lays down a bright line for distinguishing permissible from impermissible reimbursement: Educational costs will not be reimbursed if they are the result of a “redistribution of costs from educational institutions or units to patient care institutions or units.”” *Thomas Jefferson University v. HHS*, U.S. Supreme Court, June 24, 1994

• “For cost reporting periods beginning on or after July 1, 2010, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians’ offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital’s resident count if ... [t]he hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting.... The hospital is subject to the principles of community support and redistribution of costs as specified in §413.81.” 42 CFR 413.78(g), November 24, 2010

Creating the Balance

• The GME Consortium must balance
  – Accreditation: ACGME
  – Medicare/Other Funding Sources (Clinical Operations)
  – Teaching Hospitals
  – College of Medicine
  – Teaching Faculty
  – Residents
What is a GME Consortium or Collaborative?

• Graduate medical education (GME) consortia are formal associations of medical schools, teaching hospitals, and other organizations involved in residency training, with central support, direction, and coordination allowing members to function collectively.

• Collaboratives are one step removed from the program operations, but coordinate resources.

What is a GME Consortium?

• Consortia are often COM-centered, which is appropriate, given the key role of the academic institution partner.

• Consortia must also be hospital-centered: it is where key Medicare funding is – at least for now.

• Consortia must be physician-centered: without the teachers there is nothing.

• Consortia must be resident-centered: the residents are the goal.

To Medicare, the GME Consortium is the **GME Administrative Entity** who works with the teaching hospitals, and GME Consortia receive zero $ directly from Medicare.
Common Consortium Functions

- Hold the accreditation from the accrediting body: institutional accreditation of multiple programs can ease accreditation survey burden
- Centralize GME administration: coordinate rotations
- Employ/contract with the Residents
- Organize and facilitate didactic and research components
- Centralize educational resources, e.g. medical library
- Coordinate/embody financial arrangements and take the steps needed for participating teaching hospitals to meet Medicare DGME/IME rule requirements

GME Consortium Participants

- Teaching Hospitals/Health Systems
  - Financial link to Medicare reimbursement
- Physician Groups with Teaching Faculty
  - Educational resource
- Medical Schools
  - Accreditation link, academic support
- Consortium Organizing Entities
  - Purpose built entities to embody the Consortium Structure
- Public Entities

Given that each of the participants in the consortium may be performing very different functions in support of the GME programs, the relationships to the consortium vary
Advantages of Consortiums

- The power of the “collective group”
- Cross institutional research
- Administrative streamlining
- Coordinated resources
- The recognition and development of intra-organizational platforms

Model 1: MCWAH Sponsoring Institution

- Medical College of Wisconsin Affiliated Hospitals (MCWAH) is a separate and distinct tax-exempt, non-profit organization established for the purpose of coordinating funding, organizing, and sponsoring GME programs and activities at participating organizations. MCWAH currently offers 126 residency and fellowship programs, with more than 850 residents.
- The new North and Central Wisconsin teaching hospitals, physician groups, and health systems would join MCWAH as new funding members, alongside all of its existing members. All need to agree that expanding MCWAH to include additional programs in Central and Northern Wisconsin works for the MCWAH structure.
- Participating teaching institutions support the financial operations of the consortium, with proportionate support calculated based on the number of residents trained or other allocation methodology.
- MCWAH is the Sponsoring Institution, it governs all of the programs, contracts with residents, arranges for all residents’ benefits, contract with teaching hospitals for infrastructure support and acquires the teaching physician services.
Model 2: New Separate Entity

- Consortium Corporate Bylaws serve as the primary document to establish the role of the consortium and the financial support of the member hospitals and health system
- Consortium entity holds the accreditations and is the sponsoring institution for all programs of all participating institutions
- Affiliation or funding agreements may still be needed with members: member hospitals primary source of funding and accrediting bodies keenly focused on long-term financial stability
- Consortium is a “GME administrative entity” for Medicare/CMS purposes

Model 3: WI GME Collaborative

- Collaborative functions as GME clearinghouse to coordinate and facilitate the training of residents at multiple sites in North and Central Wisconsin
- Some of the Collaborative Participants sponsor their own GME programs and MCWAH may sponsor some programs, and the Collaborative facilitates GME resource deployment across all sites
- Funding occurs separately, under individual agreements
- With less integration, Antitrust issue may be present to manage
The Scope and Purpose of a GME Consortium Can Vary

- Collaborative to facilitate the establishment of new graduate residency programs
  - New core programs, e.g., FM, IM, Psych
  - New Rural Training Track programs
  - Coordinate/Promote new sites
- New GME Consortium: To be the core organizational structure for the new programs in North and Central Wisconsin
- To organize the collective GME enterprise across all MCWAH sites in the state with multiple participants

The Three Models

- Model 1: Very hi integration, with single structure covering a large section of Wisconsin: Medium complexity, because MCWAH already exists, but is that the “right” structure for the new regions? Does this “change” MCWAH?
- Model 2: Full Integration with each Consortium Member participating in funding and governance of the Consortium’s programs: High complexity, because new GME consortium structure needs to be created, but can be purpose built for the new regions
- Model 3: Low Integration: Cooperative Resource Sharing platform; as complex – and helpful - as the participants want it to be; due to absence of financial integration, there will be limits on cooperatively made decisions
Medicare GME Reimbursement Development

• Geographic Reclassification

• Two methods for a hospital to reclassify
  – Urban to rural reclassification under 42 CFR 412.103 - aka Section 401 Reclassification
  – MGCRB wage index reclassification under 42 CFR 412.230 et. seq.

• Prior CMS policy prohibited hospitals from having both; providers challenged CMS and won

• MGCRB reclass does not impact medical education payments, but 412.103 reclass may

Geographic Reclassifications (con.)

• For medical education payments, 412.103 reclassification treats the hospital as rural for some purposes & urban for others

• Rural for:
  – 30 percent upward adjustment to existing IME FTE cap under 413.79(c)(2)(i)
  – Can build new program IME FTE cap under 413.79(e)(3)

• Urban for DGME FTE cap – i.e., no DGME FTE cap increase and cannot build new DGME FTE cap

• If rural status remains for 10 years, changes may become permanent

• Rural Track Training Programs?
Questions?

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