



Models of Education Health Centers

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Advantages and Disadvantages of:

- CHC as Sponsoring Institution
- CHC as Consortium Partner
- CHC as Outpatient Training Center



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Models of Education Health Centers

Background

The Patient Protection and Affordable Care Act (ACA), signed into law by President Obama on March 23, 2010, created a new funding mechanism for ambulatory clinics that either sponsor primary care residency programs or are integrally involved in a consortium that sponsors a primary care residency program. The program creates new residency sites to move training out of academic teaching hospitals and into community-based settings, where most medical care across the country is delivered. Studies have shown that residents trained in community health centers or rural communities are more likely than those trained in other settings to make a career practicing in underserved or rural areas. [Morris C., Chen F., et al: “Training Family Physicians in Community Health Centers: A Health Workforce Solution” *Journal of Family Medicine*, April, 2008]

The Teaching Health Center Graduate Medical Education (THCGME) program was the only new investment in Graduate Medical Education (GME) in the ACA, and the five-year (2011-2015) funding of \$230 million – a tiny percentage of overall annual GME spending of more than \$10 billion – is expected to produce 600 new primary care residents by 2015. Although these physicians will serve thousands of patients, the scope of the need in this country is so great that there is no doubt that significantly expanded outpatient training will be needed. As of this writing (July 2013), unless Congress acts, the THCGME program will wind down in 2015.

Although Education Health Centers (EHCs) existed prior to the enactment of ACA, this new funding from the Health Resources and Services Administration (HRSA) resulted in at least 43 new residency programs with approximately 345 slots over a three-year period (Personal communications, K. Gordon, June, 2013). Due to the new program, Community Health Centers (CHCs) that were previously not able to host an active residency program found that they had the necessary support to design and implement models of primary care residency programs, work that is typically outside their scope of clinical practice and community service.

This white paper aims to highlight the three models of sponsorship and/or involvement in primary care residency training that CHCs can adopt. Brief descriptions of the structure, key business points, major revenue and expense categories as well as the model’s advantages and disadvantages are included for each model.

For the purposes of this paper, an Education Health Center (EHC) is distinguished from a Teaching Health Center (THC) in the following way: an EHC is defined broadly as any entity that combines both service provision and residency training in a CHC setting, whereas THC refers to the specific subset of EHCs that are funded by the HRSA THCGME program. HRSA’s THCGME program was authorized as a five year demonstration project through Section 5508 of the Patient Protection and Affordable Care Act of 2010. The Act provides for payment, up to \$150,000 per primary care resident per year, to “Community based, ambulatory patient care centers” (community health centers, entities that predominantly serve the underserved, or consortiums where the health center plays an integral role) that sponsor a primary care residency

program. For the purpose of THCGME, “primary care” includes residencies in Family Medicine, Internal Medicine, Pediatrics, OB-Gyn, Geriatrics, Medicine-Pediatrics, Psychiatry, and General or Pediatric Dentistry. Funding may only go to newly accredited primary care programs or any expanded slots of existing primary care programs, as the purpose of this legislation was to increase teaching capacity.

Models

1) CHC as Sponsoring Institution

The Accreditation Council for Graduate Medical Education (ACGME) defines sponsoring institution as “the organization (or entity) that assumes the ultimate financial and academic responsibility for a program of [CMS-supported Graduate Medical Education (GME)]. The sponsoring institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner’s office, a consortium, an educational foundation).”

http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/ab_ACGMEglossary.pdf

Largely due to HRSA’s THCGME funding program (<http://bhpr.hrsa.gov/grants/teachinghealthcenters/index.html>), more CHCs are becoming the sponsoring institution of primary care residency programs.

Structure

In the CHC-sponsored model, the CHC takes full responsibility for the residency program. This includes not only financial and outpatient training in ambulatory settings, but inpatient training that occurs in acute settings such as rotations in ICU, Surgery, and OB-Gyn. Because of the inpatient training requirements, a relationship with an acute-care hospital is required. There are common requirements that the accrediting entities have that pertain to the hospital–CHC relationship, such as the existence of a “Program Letter of Agreement” that details the educational goals and objectives of each rotation. Within each specialty, there are additional specific accreditation requirements as it pertains to the inpatient environment. These inpatient requirements address physical plant (e.g., presence of available call rooms), teaching substrate (e.g., numbers and types of patient cases available for training purposes) and resident well-being (e.g., meals available for residents).

However, CHCs can sponsor a residency program even without the THCGME program. In those situations, negotiations must occur with a potential hospital affiliate to pay the CHC for the costs of the residency program via the Direct and Indirect GME funds it may garner from the Centers for Medicare and Medicaid Services (CMS). For this model to work, the hospital must have never trained residents and thus show zero residents on their cost report. Hospitals that have zero residents on their 1996 cost report have a “cap of zero” as it pertains to Graduate Medical Education (“GME”) funding. This should always be verified with the hospital’s Fiscal Intermediary, however. Hospitals with a cap of zero have five years to create a new cap,

provided they start a new residency program. CMS has a very specific definition of “new”. Assuming the hospital meets all of the aforementioned thresholds, they can receive both Direct GME (“DGME”), which covers Medicare’s share of the residents’ salaries and benefits, and Indirect GME (“IME”) which was created in 1982 to cover any excess utilization, such as increased lab orders or imaging tests, by residents in the inpatient setting. How much DGME and IME a hospital receives is a function of their Medicare percentage, their number of beds, and the number of residents that will be training at that hospital, amongst other things. CHCs that wish to trigger the hospital’s cap will need to work closely with the hospital as the CHC 1) negotiates with the hospital to cover all costs of the residency program and 2) give careful consideration and strategically plan for how many resident FTEs the hospital will be capped at when it hits the five year mark.

Key business points

Consider these business points when structuring a CHC-sponsored residency program:

1. Revenue

Will the CHC be funding the program via THCGME funding, CMS GME funding, or a combination of both?

The types and terms of legal agreements will vary based upon the answer to this question. For example, ACGME requires that all residency programs have “Program Letters of Agreement” (PLA) in place with their rotational sites. A PLA is a document that delineates the educational goals and objectives of the rotation occurring at the site. However, if the CHC is receiving GME funds from a hospital, the terms and conditions of the funding must be legally defined in addition to having the PLA in place. Specifically, the hospital must demonstrate, via a legal agreement, that the hospital is paying all of the resident’s salaries and benefits. This can be demonstrated either in the PLA or a separate legal agreement.

2. Structure

Is this a new program, or a change in sponsorship from a hospital-sponsored model to a CHC-sponsored model?

Because THCGME funding requires a central role for a CHC, many residency programs had to change their sponsorship to a CHC to gain access to the funding stream. In that scenario, the required business points and wind-down provisions (the terms that delineate what happens should the relationship terminate) differ from those of a CHC that started a residency program from “scratch.” For example, if a CHC assumes sponsorship of an existing program, the question of who will employ the existing faculty arises. Will they be terminated and then employed by the CHC, thereby making the faculty eligible for FTCA coverage, or will they continue under their existing employment arrangement via a leasing agreement? If the contracts terminate for any reason, will the program be returned to the original sponsor (i.e. the hospital)? And since the “Family Medicine Center” usually changes from a hospital operating it to a CHC as well, what will happen to the patients, should the contract terminate? These issues are not at the forefront of the business plan when a CHC starts a program from scratch.

Revenue

When a CHC is the sponsoring institution, it almost always also provides the ambulatory training environment for the residency program. A key consideration when providing the outpatient

training environment is the impact on patient volume and, hence, on clinical revenue. ACGME has hard minimums (n=1,650) and soft maximums (n=2,300) for the number of patients a resident can see over the course of three years of training. Without careful planning, CHCs can find that they have decreased their revenue by functioning as a teaching site. However, with careful planning, having residents can result in the same number of patients being seen in the outpatient setting as if there were no residency program. Either way, the assumptions need to be documented and incorporated into the pro-forma as a deduction or increase in revenue. For example:

- Will the CHC be displacing providers in order to accommodate the residents and preceptors? If so, how does the providers' volumes per half day compare to the resident and preceptors' volumes per half day? Post Graduate Year-1 ("PGY-1") residents see, on the average, six patients per half day, so during year one, for those half-days where a fully functioning provider is displaced by PGY-1 residents, a reduction in revenue should be incorporated into your proforma.
- If the CHC is not displacing providers and the CHC has rooms with capacity available, then the resident and preceptors visits represent an increase to revenue.
- By PGY-3 (the third year of residency training) the residents will be performing as good as or even better than existing providers regarding patient volumes. This difference, should there be one, should also be incorporated as incremental revenue to the proforma.

A CHC as sponsor may receive funding from many sources. It is imperative that there is no "double dipping" of revenue and hence no violation of federal or state rules regarding residency training reimbursement.

1. Traditional GME (from hospital partners) – Under the CHC-sponsored model, hospitals frequently direct some or all of the Direct and Indirect GME funds received from CMS into the CHC. Many rules and regulations pertain to this, such as what constitutes an allowable rotation, what constitutes an allowable resident, etc., so it is wise to have a cost report consultant or an expert in GME retained to guide you through this process.
2. Community benefit grants/donations – Hospitals may decide to support the CHC beyond directing Direct and Indirect GME funds to the CHC. To the extent that this occurs, a "Community Benefit Grant" ("CBG") is awarded to the CHC by the hospital. A CBG is a contract, drafted by legal counsel, that allows for the hospital to provide funds to a non-profit entity in such a manner that does not violate Stark and/or anti-kickback laws. As such, the agreement should clearly state that there are no expectations of referrals by virtue of the funds being given.
3. Contracts and grants – A CHC, as a non-profit organization, is able to obtain contracts and grants for services and research endeavors.
4. THCGME – This is HRSA funding for new or expanded primary care residency programs under a five-year demonstration project. As of this writing, the funding formula for direct and indirect costs has not been released, resulting in current THCGME funding remaining at \$150,000 per THC resident, provided the costs of training the resident that are incurred by the CHC support that level of payment. The future of this program is unclear, as the funding is scheduled to sunset in 2015 and has not been re-authorized, let alone appropriated, at this time.

Expense

The expenses for a residency program are primarily driven by the Program Requirements of each subspecialty. For example, in Family Medicine, there is a required Program Director, a required residency coordinator, a required .25 behaviorist, and a 1:6 core faculty to resident ratio, amongst many other requirements. Each of these requirements results in a cost to the program, with some not resulting in any offsetting revenue. The Program Requirements are usually minimums and not maximums. For example, a requirement of one faculty for every six residents is a minimum and may vary depending on the available resources for teaching on the inpatient service.

One expense item that always generates discussion is Federal Tort Claims Act (FTCA) coverage. Faculty must be either directly employed by or under legitimate independent contractor agreements with the CHC to be covered by FTCA. Residents must be employed by the CHC to obtain FTCA coverage. And the CHC must submit a change in scope to BPHC to incorporate the teaching activities. Note also that residents will see and conduct rotations with non-CHC patients, so gap malpractice insurance is a necessary expense as FTCA may not cover the residents' activities in these situations.

Advantages

1. CHCs certainly offer rich curriculum opportunities for resident trainees that traditional hospital sponsors are unlikely to be able to provide, such as experience with team-based care within a PCMH framework, population/community-wide health initiatives, and specific service programs, such as mobile vans, community outreach programs, teen pregnancy programs, etc.
2. Within this model the CHC has complete control of the residency program. This is favorable for the CHC but may make the hospital partners nervous. It should be noted however that this also puts the fate of the residency program entirely in the hands of the CHC, with the resultant risk to the residency's viability should the CHC decide it no longer wants to sponsor a training program.
3. The legal agreements are simplest under this model.

Disadvantages

The primary disadvantage for a CHC as the sponsoring institution is the cultural differences between training programs and CHCs. **It is critical not to underestimate the implications and possible difficulties this issue presents.** CHCs are about service, residency programs are about education, and the two cultures can clash - very powerfully at times. The board and senior leadership of the CHC must be aware of this and steadfast in their commitment to the dual mission of both clinical service and education.

Note that the CHC will need to submit a change in scope to HRSA to include teaching of residents. A change in scope request will require the submission of appropriate BPHC documents, along with copies of the financial proformas detailing that this new activity will not result in resources being reduced for patient service activities and a copy of the legal agreements governing the residency program relationship.

2) CHC as Consortium Partner

Consortia for community-based ownership of Graduate Medical Education are dynamic and viable approaches to GME sponsorship (Broderick and Nocella, 2011). In 2010 the ACGME

identified only 10 Institutional Sponsors who self-identified as a “Consortium of Hospitals” (Miller, R., *Personal Communication*, "GME Consortia as Institutional Sponsor", 11/18/2010, ACGME). By contrast, during the three THCGME funding cycles since 2010, there have been at least 10 consortia as applicants for the THCGME funds from HRSA. This information, plus anecdotal reports, tells us there is interest and activity in developing consortia as models for sponsoring primary care residency programs.

Structure

There is no universally accepted structure for a consortium, with many different models and no definition of best practice. Webster defines consortium as “an agreement, combination, or group (as of companies) formed to undertake an enterprise beyond the resources of any one member.” That definition speaks to the spirit and reality of GME consortia, particularly where CHCs are concerned. Primary care residency programs, particularly for the specialty of Family Medicine, require robust ambulatory environments, something that CHCs are well poised to provide. But they also require acute-care hospital settings for not only inpatient training but in some cases because the CHC needs the CMS GME funding, and even the leasing of the academic infrastructure such as the GME Committee that governs the academic integrity of all residency programs within an institution. The training program may require educational opportunities from more than one acute-care hospital, a surgery center, or a nursing home, all of which may make for strong consortium members. As demonstrated here, none of the entities possess all the requirements for a training program, but together they create a sum that is greater than the parts.

Often consortia are organized as not-for-profit, 501(c)3 corporations, with articles of incorporation, by-laws, and a board of directors. Great care needs to be invested in the creation of the by-laws since they govern the actions of the board of directors and include such sensitive issues as voting rights. In order for a consortium to function effectively, all participants must feel safe, and the best way to achieve safety is through carefully crafted by-laws.

Key business points

The business elements of the by-laws, and any subsequent definitive agreements, should be developed by the consortium participants in a collaborative and transparent process. Key points to consider include:

1. “Pay to play”: the identification of which organizations are willing to put funds behind their participation, contribute members to the board and participate as designers of the by-laws. Often many want to participate, but few will put resources behind their participation. Knowing who is willing to contribute resources, whether cash or in-kind, is critical to the decision of who “gets a seat at the table.” It is essential that this point be established early in the process, and that partners are clear that “participation” by organizations positioned to benefit by having a residency program within the community does not mean going to meetings alone, but also committing tangible monetary or personnel resources to the effort.
2. How budget deficits and even budget surpluses will be dealt with (yes, they do happen!). Do the parties share equally in the losses or gains? Sharing in the gains could violate tax and legal rules regarding non-profit status, so this issue needs to be thought through very carefully. If not sharing equally in losses, then what metric will determine how losses will

be shared? It is critical that this be determined before the end of the fiscal year, when actual financial results are known.

3. “Unwind provisions” should be articulated in a kind of “pre-nuptial agreement.” We have found that, in response to recent funding opportunities, consortia have been quick to form or restructure with too little consideration of what happens if the parties can’t continue to work together, whether due to lack of funding, disagreements, changes in law, or a host of other factors. Planning in advance how to unwind the relationships before having to do so is an important part of developing your definitive agreements. This is particularly important when the consortium has taken on the responsibility of being the sponsoring institution. Proactive decisions in this regard will help avoid disastrous endings, which is particularly important when lives and careers of residents are involved.
4. Finally, some terms unique to each consortium will need to be heavily protected in the by-laws in order for entities to feel safe enough to proceed. Examples might include which entity has first right of refusal on the residency program should the relationships terminate and provisions for a financial “true-up” process so that one entity does not experience unanticipated losses, etc. Supermajority voting rights, where a 2/3 vote of the board is required for certain decisions to be made, are a wonderful tool when an entity needs a certain level of control or protection over a specific issue. For example, an entity, such as a hospital, that releases sponsorship of a residency program to a consortium in order to qualify for THCGME funding may want to establish a sufficient comfort-level through requiring supermajority approval by the consortium board before any deleterious decision is made pertaining to the residency program.

Revenue

The consortium model has four categories of revenue:

1. Traditional GME (from hospital partners) – Under the consortium model, hospitals frequently pay the consortium some or all of the Direct and Indirect GME funds received from CMS. Many rules and regulations govern this, so an expert consultant in GME should be retained to guide you through this process.
2. Community benefit grants/donations – Hospitals may decide to support the consortium beyond their receipts of Direct and Indirect GME. To the extent this occurs, a “Community Benefit Grant” is awarded to the consortium by the hospital, clearly noting in the agreement that there are no expectations of referrals by virtue of the funds being given. Additionally, CHCs may decide to contribute to the consortium as an acknowledgement of the value proposition it receives by having residents in its environment.
3. Contracts and grants – Consortia, as non-profit organizations, are able to obtain contracts and grants for services and research endeavors.
4. THCGME – As explained in the “CHC-as-Sponsor” section above, this is the HRSA funding under a five-year demonstration project. As of this writing, funding is \$150,000 per resident, if the residency training costs incurred by the CHC support that level of payment. The future of this program is unclear.

Expense

Consortia have certain overhead costs that other models of GME sponsorship do not have, such as Directors and Officers liability insurance, clerical support, etc. At a minimum, Directors and

Officers insurance, liability insurance, legal expense, accounting expense, and some staff expenses must be covered.

Advantages

One of the most significant advantages to a consortium model is the community level of ownership inherent in the model. Instead of a model of residency training where one hospital is responsible for the financial integrity of the program, a consortium is structured so that many entities have financial responsibility. Residency programs that have all of their financial resources tied to one entity are at risk, should that entity decide to cut, or eliminate, the program's budget. With all entities contributing in a consortium model, the withdrawal of a single partner won't necessarily negatively affect the residency program.

Another significant benefit is the engagement of multiple community organizations in a dialogue about what is important to that particular community in its approach to medical education, in contrast to the more siloed approach of the traditional model of institutional training. In support of the collaborative approach, community organizations can bring input or additional partners from their own networks to the table. In addition, a platform is provided for much greater awareness on the part of each partner of what all the other partners are thinking and doing in relation to medical education in their community. A residency consortium creates a vehicle for conversation that then facilitates other discussions such as on Accountable Care Organizations (ACOs) and clinical coordination.

Disadvantages

The chief disadvantage is that the program director now has an entire board to manage and please rather than just the CEO of a sponsoring hospital or CHC. This requires a program director with strong leadership and interpersonal management skills.

3) CHC as Outpatient Training Center

Structure

Under this model, some other entity like a hospital or a consortium is the sponsoring institution, with the CHC serving as the continuity ambulatory training site for the residents.

Key business points

This is the most difficult model to structure because, invariably, the faculty are employed by some other organization than the CHC. This results in areas of conflict between the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) requirements and ACGME/AOA requirements (AOA is the American Osteopathic Association, the osteopathic accrediting body). For example, HRSA requires that CHCs have complete responsibility and control of their clinical operations. ACGME requires that the Program Director have complete responsibility for all training activities. When the resident is being supervised in the CHC, the ACGME will consider that a training activity, while HRSA will consider it a clinical activity. The parties must figure out a way of satisfying both BPHC and ACGME requirements. This is just one example of many potential conflicts between the

accrediting/licensing entities and the federally-funded institutions. These conflicts can be resolved, but they require a fair amount of conversations and legal advice to do so.

Revenue

Impact on Capacity: as explained in the Revenue section of the “CHC-as-Sponsor” section above, a key consideration when providing the outpatient training environment is the impact on patient volume and hence, revenue. With ACGME’s minimums and maximums of the number of patients a resident can see over the course of three years of training, careful planning is needed by a CHC to avoid decreased revenue by functioning as a teaching site. As discussed above, with careful planning the same number of patients can be seen in the outpatient setting as in a non-residency. Again, assumptions need to be documented and incorporated into the pro-forma.

The CHC should thoroughly understand, document and contract with the sponsoring institution for reimbursement for expenses directly attributable to having residents. It is extremely important that these costs not be underestimated and that they be fully reimbursed.

Expense

Under this model the CHC has no direct residency related expenses due to the presence of the program. Some Sponsoring Institutions may develop a professional services agreement if they are providing faculty and residents and essentially filling vacant positions at the CHC. For example, instead of filling a vacant physician provider position with a full-time clinician, the position may be filled with a core faculty member and four residents. In such situations, nothing more than fair market value should be paid.

Advantages

The CHC has relatively little responsibility in this model. The advantages to the CHC include recruitment opportunities with residents and improved clinical staff retention through increased job satisfaction from teaching.

Disadvantages

Challenges include the drafting of legal agreements and operationalizing the program without control over the residency program. There are also cultural differences between CHCs as “service” organizations and residency programs as “educational” organizations that not only need to be discussed, but also should be reflected in the definitive legal agreements.

Discussion and Conclusions

The success of CHC recruitment and retention of residents trained at a CHC, despite the challenges, is well supported by research (Morris and Chen, 2010, Morris, 2008, Chen, 2010). Because of the wide variation in the models and the intricacies inherent in each, a team of experienced people is required to assist the CHC in development and implementation of the program. The Education Health Center Initiative (EHCI) offers expert consulting services to help CHCs and family medicine residencies create and expand their education health center programs. EHCI’s mission is to develop training and workforce solutions for the provision of quality primary care to underserved populations through support and transformation of primary care health workforce training partnerships.

Consult www.educationhealthcenter.org for more information, including a 90 page toolkit and documents pertaining to:

- Research and surveys
- Fiscal issues, costing spreadsheets, etc.
- Legal issues and agreements
- Governance
- Administration
- Accreditation process

EHCI offers initial one-hour consultations with one of our consultants free of charge. Contact projectmanager@educationhealthcenter.org to schedule a time.