EHCI THE EDUCATION HEALTH CENTER INITIATIVE

www.teachinghealthcenter.org

Supported with funding from The Josiah Macy, Jr. Foundation

Family Medicine Residency Network www.wwwamnetwork.org

UNIVERSITY of WASHINGTON DEPARTMENT OF FAMILY MEDICINE

NORTHWEST REGIONAL PRIMARY CARE ASSOCIATION Alaska · Oregon · Idaho · Washington

Community Health Association of Mountain/Plains States

What is an Educational Health Center

NWRPCA/CHAMPS Fall Seminar Denver October 23 & 24, 2010

Mike Maples, MD
Family Doctor (since 1983)
Founding Director, Central Wash Fam Med Residency Program, Yakima, WA (1993)
Founding CEO, Community Health of Cent WA, Migrant and Community Health Centers, Yakima and Kittitas Counties (2003)

Educational Health Center …focusing our conversation

The CHC is the primary outpatient training venue

Training physicians

Health provider education

Education in a CHC

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Educational HC Strictly Defined

- A health center that serves as the site for the continuity clinic of a residency program
  - The residents (and likely faculty) of the program are primary care providers for the CHC

RC – FM Req: IV.A.5.a).(2).(c).(iv).(b) A resident must be assigned to one FMC, preferably for all three years, but at least throughout the last two years of training.
IV.A.5.a).(2).(c).(iv).(c) Residents must be scheduled to see patients in the FMC for a minimum of 40 weeks during each year of training.

"Teaching Health Center"

- Now has a specific meaning because of its definition in the Affordable Care Act
- Describes a ***funding mechanism*** for an EHC

More Focus: Family Medicine

- Your presenters are family doctors
- It is the specialty most in need at CHCs
- Almost all examples of existing EHCs are Family Medicine programs
- Every interested CHC and Program that we are aware of is a FM interest
- Don't assume that anything that we say will apply to any other specialty

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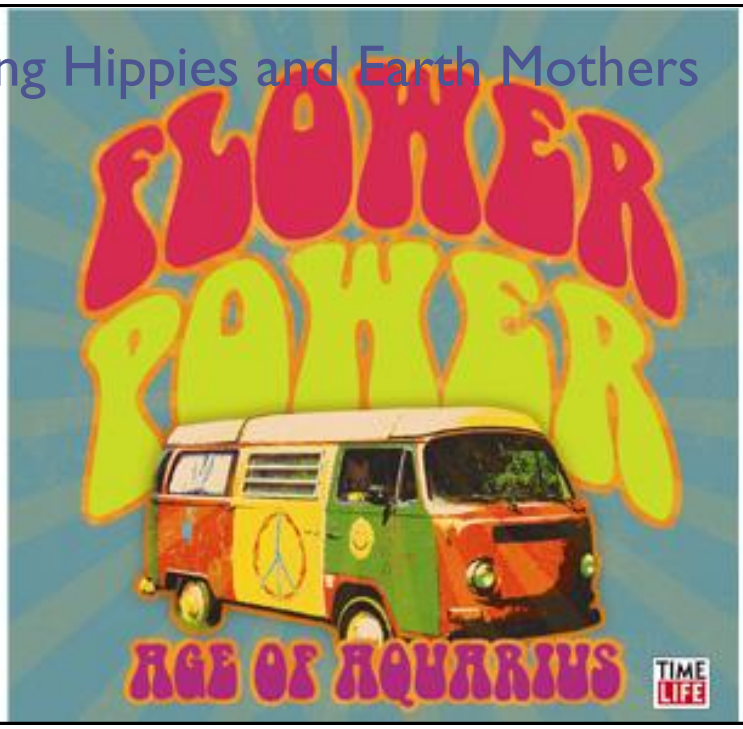
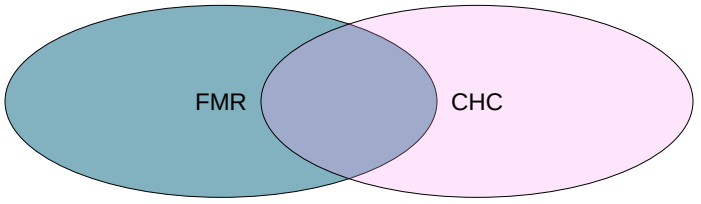
Aging Hippies and Earth Mothers

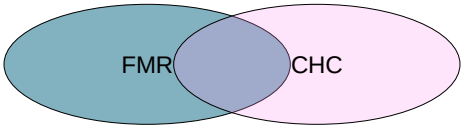


The Model



- The FMR has significant responsibility outside of the CHC
- The CHC has significant activity in addition to the FMR
- The area of overlap is large

The Path



- Existing CHC and Existing FMR collaborate
  - CHC contracts for clinical services of FMR workforce
- …or merge
  - CHC buys residency, or vice versa, or umbrella agency operates both
- Existing CHC creates a new FMR
- Existing FMR becomes a CHC
  - NAP, or Look-Alike

What will it take

- Leadership
- Collaboration
- Time
- Money

Leadership

- Lead the development of the vision of the new or reinvented training program
  - With the Board, CHC providers and staff, stakeholders
- Communicate the vision to the community, especially the medical community
  - Recommend strong physician leadership
- Change Management

Collaboration

- The accredited program must have
  - Teaching hospital(s)
    - ~1/3 of resident time in inpatient settings
  - Non-hospital rotation sites
    - ~1/3 of resident time in ambulatory rotations
    - Will involve dozens of volunteer teaching physicians
  - Only about 1/3 of resident time is in the CHC delivering outpatient care to the CHC patients

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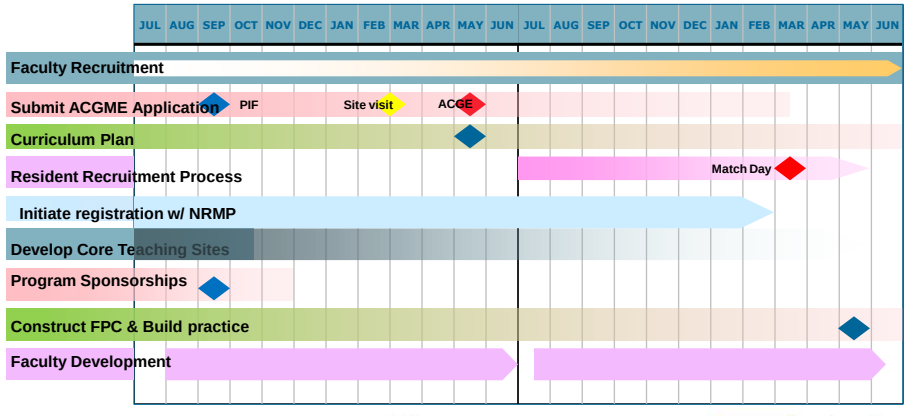
Time: from the time that the leadership/vision/collaboration issues are worked out, it takes about 2 years



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Money…Start-Up Funds

- Investment
- Collaborative funding
- Grants
  - HRSA
    - Section VII
      - Title 747
      - NEW: Title 749A….pending appropriation
  - Other

Call for HELP: Consultants

- Peers
- TA: tbd
- Finance:
  - Joel Hughes; Cheryl Storey; others
- Legal
  - Leifer et al; Bennett-Bigelow (Seattle)
- GME
  - Tom Gentile; Art Bolls

Funding to Sustain the Program: today, you have a choice

- GME
  - Administered by CMS
  - ~$9 B annually
    - $6 B IME, $3B GME
  - Paid to teaching hospitals
  - Byzantine rules
  - Ties to Mcd GME
- THC
  - Admin: BHPr
  - $230M over 5 yr
    - Demo Project
  - Payable to the accredited agency
  - Rules: TBD
  - ?? Mcd payments

May be no "Pure" THC Model

Time
&
Money

GME (CMS) FUNDED:
1/3 of time in the teaching hospital
THC (HRSA) FUNDED:
2/3 time in CHC
& other outpatient settings

The CMS GME Opportunity

- May produce ample funding to sustain the program
  - Can be easily (in the right hands) estimated
  - Especially when combined with Mcd GME
- Require vigilance to maintain transparency with the teaching hospital
  - Public information
  - Return is maximized with collaboration

GME….the crash course

- Why does Medicare pay?

- The initial Medicare legislation states:
  - *Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program.*

- (House Report, Number 213, 89th Congress. 1st Sess. (1965) and
- Senate Report, Number 404. Pt 1. 89th Congress. 1st Sess. 36 (1965))

Key points and helpful hints….

- It is only Medicare's intent to cover *its portion* of the cost of residency programs
- Following the rationale for DGME, Medicare has *prepaid* for all services delivered by a resident, and will only pay for the service of the teaching physician

Medicare makes 2 types of payments

- Direct GME (GME) Payments
  - Partially compensates for residency education costs
- Indirect medical Education (IME) Payments
  - Partially compensates for higher patient care costs due to presence of teaching programs
- Federal FY '09
  - DGME payment = $2.9 billion
  - IME payment = $6.2 billion

GME (direct GME payment) covers

- Teaching institutions for costs directly related to educating residents:
  - Residents' stipends/fringe benefits
  - Salaries/fringe benefits of supervising faculty
  - Other direct costs
  - Allocated overhead costs

the Basic Methodology Underlying DGME Payments

- *Step 1:* Determine hospital-specific per resident base year cost amount (PRA) (generally 1984)
- *Step 2*: Update (to current year) base-year per resident amount (PRA) for inflation
- *Step 3:* Multiply the updated PRA by the number of residents in the current year (this amount capped by BBA resident limits)
- *Step 4:* Multiply by the hospital's ratio of Medicare inpatient days/total days

Medicare Payments with an Education Label: IME

- Compensates teaching hospitals for higher inpatient operating costs due to:
  - unmeasured patient complexity not captured by DRG system
  - other operating costs associated with the presence of GME programs (more tests, lower productivity, etc)
- Percentage add-on payment to basic Medicare per case (DRG) payment
- IME payments made only to hospitals

Calculating the IME Operating Adjustment

- The IME adjustment is based on statistical analysis using intern and resident-to-bed ratios (IRB)
- % per case add-on =
  - **Multiplier X $((1 + IRB)^{0.405} - 1)$**
- Short hand for IME: Hospitals get about a 5.5% increase in DRG payments for every 10- resident increase per 100 beds

Most "teaching hospitals" are *capped* with regard to resident FTE's

- Generally speaking, the number of FTE allopathic and osteopathic residents that a hospital may count for DGME and IME payments is limited to 1996 Medicare cost report count.
- Established by the Balanced Budget Act of 1997

The Medicare statute provides few exceptions to the caps

- **Rural Teaching Hospitals**
  - **cap = 130% of 1996 count (BBRA)**
  - **cap can be adjusted for new programs**
- **Rural Training Track Programs**
  - **Urban hospitals can get cap adjustment**
- **New Teaching Hospitals**
- **Medicare GME Affiliation Agreements**
- **Temporary Adjustments Associated with Closed Hospitals and Programs**
- **?? Add to list: Teaching Health Center FTE**

NEW Teaching Hospitals: 2 important variables to determine

- Per Resident Amount
  - Lesser of actual costs OR average of 3 teaching hospitals in the: wage area > census region> state
- FTE Cap
  - 3 year window
  - Clock starts when the hospital trains residents in the first NEW program

The THC Opportunity

- Administered by the BHPr
- Rules: TBA
- CHC must be the "accredited body" (sponsoring institution)
- Provides for payment of direct and "indirect" expenses of the program
- Other revenue…?

Another ACA Opportunity: Section 5503

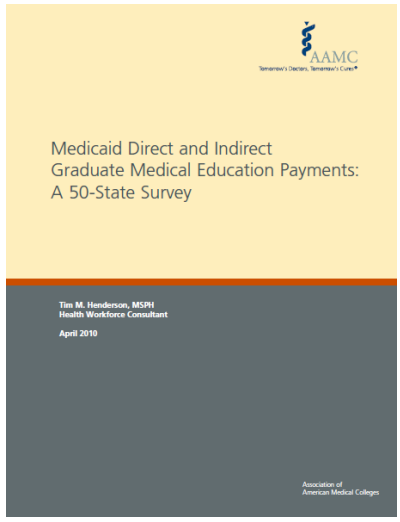
- Redistributes unused resident FTE's to existing teaching hospitals.
- Priorities:
  - Resident to population ratio (lowest quartile)
  - Population residing in HPSA (top 10 states)

If your state is not on one of these lists, and not a rural hospital, you cannot qualify for this program.

13 States with Lowest Resident-to-Population Ratios	10 States with Highest Proportion of Population Living in a HPSA
Montana	Louisiana
Idaho	Mississippi
Alaska	Puerto Rico
Wyoming	New Mexico
Nevada	South Dakota
South Dakota	District of Columbia
North Dakota	Montana
Mississippi	North Dakota
Florida	Wyoming
Puerto Rico	Alabama
Indiana	
Arizona	
Georgia	

What about Medicaid?

- Second-best payer of GME
  - Nearly $4 billion in 2009
  - 41 states…and fading
- 50 states. 50 solutions
- Typically follows CMS
- ?? Funding to follow THC??



Discussion and Questions

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