Medicare GME Funding for Rural Residencies – hot issues with rule changes and hospital reclassifications

Lou Sanner, MD, MSPH, FAAFP

A partnership between

UNC SCHOOL OF MEDICINE

School of Medicine and Public Health
UNIVERSITY OF WISCONSIN–MADISON

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Disclosures

RRPD-TAC is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement #UK6RH32513.

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Partners and Key Stakeholders

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Objectives of this talk

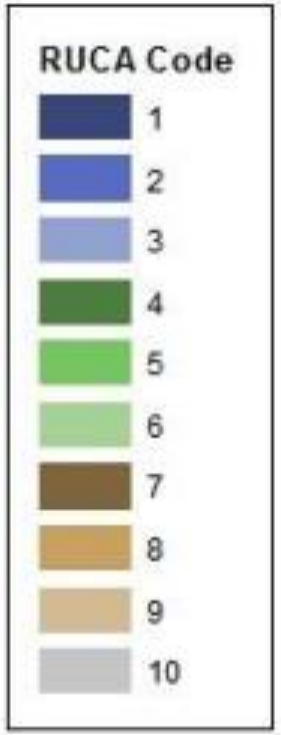
- Understand that locations and hospitals may be deemed **“rural” vs “urban”** by the Centers for Medicare and Medicaid Management (**CMS**) vs the Federal Office of Rural Health Policy (**FORHP**) and why that matters.
- Understand that hospitals have both a rural-vs-urban **location** and a rural-vs-urban **categorization** and these may be different.
- Understand that location/categorization can **change** for your hospitals and clinics and why this matters – a lot – for planning/managing GME programs.
- Work through several cases of new and old residencies that have faced **challenges and opportunities** due to this location/classification phenomena.

Rural locations - CMS definition

- “CMS rural” means that the location is not in a Major Metropolitan Area (MMA).
  - Either Micropolitan CBSA (light green) or not in a CBSA (white)
  - County level designations
  - Training in a “CMS rural” place counts towards the RTP rules for >50% rural training.

Rural locations - FOHRP definitions
(Federal Office of Rural Health Policy)

- “FOHRP rural”
  - Much smaller census divisions used
  - Many gradations of rural using RUCA codes
  - RUCA >=4.0 used to qualify applicants for the Rural Residency Program Development (RRPD) HRSA grant program.



Rural locations – how to know?

- “Am I rural?” website maintained by FORHP tells all and is very up-to-date
- Ruralgme.org website “Hospital Analyzer” shows location/classification for hospitals
- Ruralgme.org toolbox has a “Hospital Type and Data lookup file” which shows statewide hospital data including recent DGME and IME payments.

Hospital Analyzer

RuralGME.org

State

NC

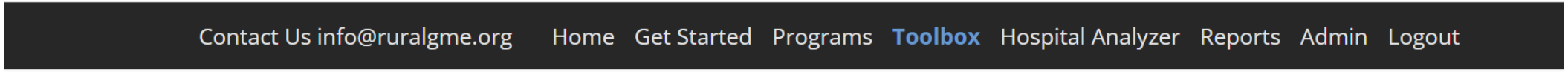
For more information on any thing listed in the report, please see the attached glossary.

City Clear

- AHOSKIE
- ALBEMARLE
- ASHEBORO
- ASHEVILLE
- BOONE
- BREVARD
- BRYSON CITY
- BURGAW
- BURLINGTON
- CARY
- CHAPEL HILL

Hospital	City	State	CCN
ADVENTHEALTH HENDERSONVILLE	HENDERSONVILLE	NC	340023
ALAMANCE REGIONAL MEDICAL CENTER	BURLINGTON	NC	340070
ALLEGHANY MEMORIAL HOSPITAL	SPARTA	NC	341320
ASHE MEMORIAL HOSPITAL	JEFFERSON	NC	341325
ATRIUM HEALTH ANSON	WADESBORO	NC	340084

RuralGME Portal Toolbox



RuralGME.org

The RuralGME team has pulled together a variety of tools and resources for rural residency program development. Each category below represents a section of the toolbox and contains some descriptive context as well as a link to the tools and resources for that particular section. You can also jump straight to the full, filterable list of tools and resources by clicking the purple “view all tools” button.

View All Tools

Community Engagement

Program Design & Development

Financial Planning

Institutional Sponsorship

Program Accreditation

Program Implementation

RuralGME.org THCGME.org

Location vs classification of IPPS hospitals

- Urban location hospitals used to be predominantly classified “urban”. Same with rural located hospitals - mostly classified “rural”
- This has diverged more in recent years with ~56% of residents and fellows in the US now training in urban/rural (location/classification) IPPS hospitals.
- There are many routes to getting reclassified as rural (a 412.103 reclass)
  - a common one is to become a Rural Referral Center (RRC)
- In general, **location drives DGME** rules while **classification drives IME** rules.

Location vs classification of CAHs

- Most CAHs are rural/rural (location classification)
- Some CAHs are urban/rural because they meet federal distance/size criteria even if in an urban place or have a governor's designation.
- Critical Access Hospitals (CAH) can also *become* urban/rural via several routes – one is to:
  1. start out rural/rural
  2. undergo a census county change (the 2020 census!) to an MSA which makes the CAH urban/urban
  3. The CAH can then must apply to remain rural classified or lose CAH status. Their location remains “urban” - so they are now an “urban/rural” CAH
- There are no urban/urban CAHs or rural/urban CAHs

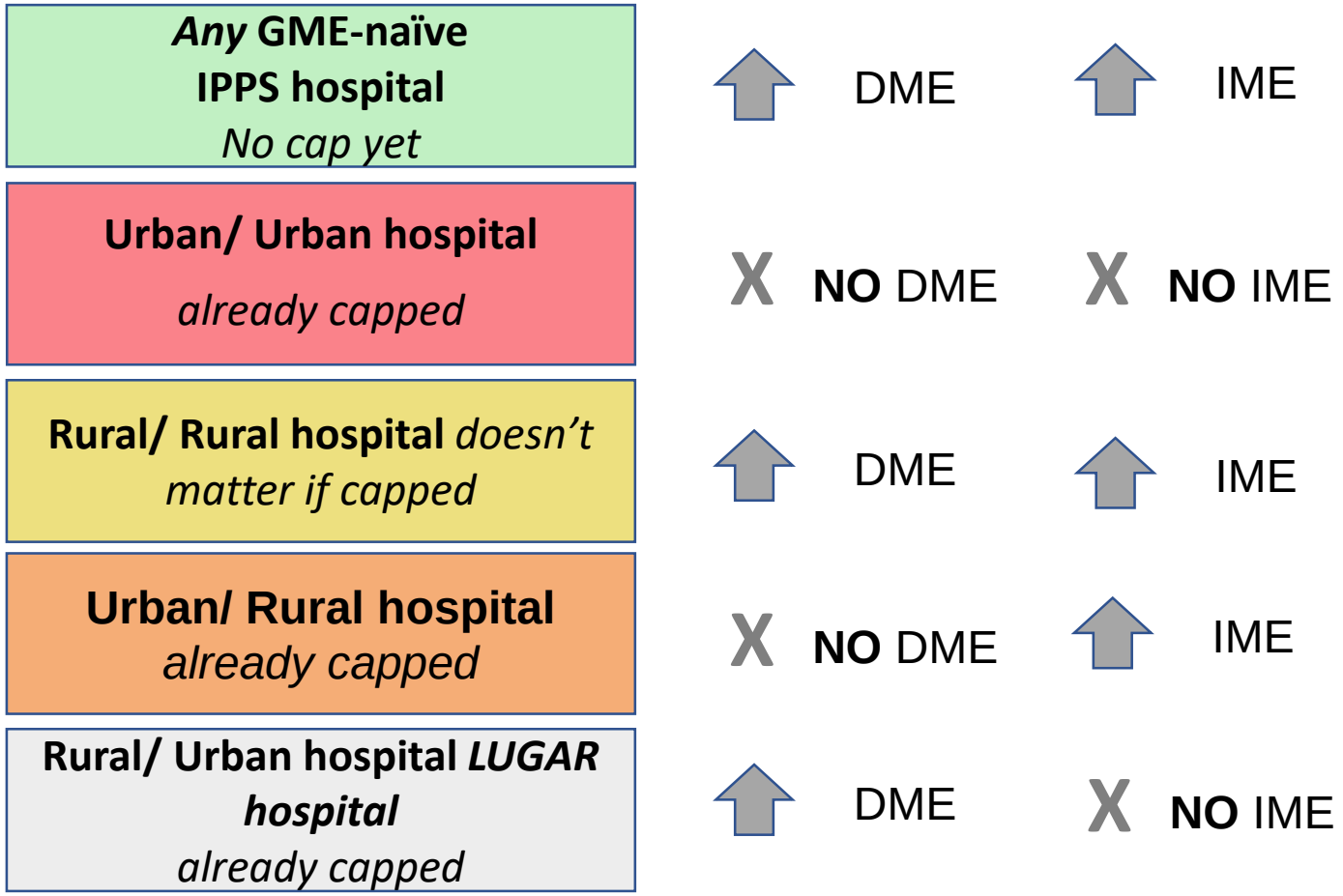
“New program” vs “expansions” of current programs

Critical distinction when looking at financial implications for growing GME, especially if seeking RTP funding

A new program must meet ALL of these criteria:

1. **Separate program director** (not listed as a PD for another program) – this currently requires separate accreditation since the ACGME will only allow one designated PD per program.
2. **Separate faculty** (not listed as “core faculty” for another program in the same specialty)
3. **Separately recruited trainees** (for residencies this usually means separate NRMP match number, for accredited fellowships evidence of a distinct recruiting process)

What happens when a "new GME program" (not RTP) starts? *Additional* GME payments and additional caps for IPPS hospitals:



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Case 1 New urban residency

not considering RTP funding even though some rotations may be rural

- A community in a metropolitan area wants to start a new residency and is considering regional partners. **Not** considering qualifying as an RTP.
- Why not RTP?: Area may be "FOHRP rural" but not "CMS rural" or specialty issues
- What are the Medicare GME funding potentials for each of these potential urban located hospital partners?
  - **A newly built GME-naïve IPPS hospital**
  - **An urban/urban capped IPPS hospital**
  - **An urban/rural capped IPPS hospital**
  - **An urban/rural capped Sole Community Hospital (SCH)**
  - **A rural/rural Critical Access Hospital (CAH)**

Note in this example we presume all capped hospitals are ***over*** their cap.

Case 1: New urban residency

not considering RTP funding

Can these hospitals get new GME funding?

- A newly built GME-naïve IPPS hospital?
  - New ***DGME and IME*** funding for ***any*** "new program".
  - No new funding for program expansions from other capped hospitals
- An **urban/urban** capped IPPS hospital?
  - No new funding (unless if starts an RTP)

Case 1: New urban residency

not considering RTP funding

continued… Can these hospitals get new GME funding?

- An **urban/rural** capped IPPS hospital?
  - New ***IME*** funding for any "new program"
  - No new DGME funding (unless it starts an RTP)
- An **urban/rural** capped Sole Community Hospital (SCH)?
  - Same as above except IME limited because an SCH, basically only IME for Medicare Advantage
- A **rural/rural** Critical Access Hospital (CAH)?
  - ***Any*** CAH can make direct residency expense claims and get "Medicare's share" + 1%
  - Time residents spend in a CAH can be claimed by partner IPPS hospital

Rural Training Program(RTP) rules
Must meet both

1. An urban located hospital (or it's provider-based clinic) is needed for ***some*** rotations
2. >50% training must occur either:
   - in a rural **location** ("CMS rural") which can be a clinic and/or hospital
   - **or** in a hospital (or its provider-based clinics) with **rural classification**
     - ➢**Even if urban located!**

Rural Training Program(RTP) rules continued

Why is training in an ***urban*** located rural reclass hospital now allowed to count towards the >50% ***rural*** training time for RTP funding?

- This new qualification is due **to judicial rulings (2015 and 2016)** that determined that **rural classified hospitals must be treated "as if rural"** for many parts of the much-amended Social Security Act – e.g. for **IME** and for **section 126 rural priority slot applications.**
- This is a problematic loophole which is having **negative effects** (entirely urban located RTPs and misallocation of section 126 slots) and **potentially positive effects** on new and old rural residencies that have difficulties otherwise meeting >50% rural training RTP funding requirements.

Partners that qualify a program for RTP funding.

Urban partner must be a hospital

Rural partner can be hospital or clinic

one hospital can't be **both** the urban and rural partner in a residency

For DGME – location matters:

Urban partner(s) at least one:

- U/U IPPS hospital
- U/R IPPS hospital
- U/R CAH (rare)

Rural partner(s) >50% training time:

- R/R IPPS hospital
- R/U IPPS LUGAR hospital (rare)
- R/R CAH or REH
- Rural located non-provider clinic

For IME – classification matters:

- Urban partner(s) at least one :
  - U/U IPPS hospital
  - R/U IPPS LUGAR hospital (rare)
- Rural partner(s) >50% training time:
  - R/R IPPS hospital
  - U/R IPPS hospital
  - R/R CAH or REH
  - Rural located non-provider clinic

The following cases: New residency (or expansion) that *wants* to qualify as an RTP

- Cases 2-7: Will they qualify for new GME funding?
- For both DGME and IME?

Case 2: U/U capped urban partner and R/R GME-naive rural IPPS partner

- **Urban/Urban** capped IPPS hospital has one or more residencies
- **Rural/Rural** IPPS hospital is GME naïve or capped
- community is “CMS rural”
- Rural clinic is a non-provider clinic in a “CMS rural” location
- How can they get funding? Both DGME and IME?
  - Get RTP funding if >50% training in rural community (rural clinic plus rural/rural IPPS hospital). **BOTH** DGME and IME
  - **RTP could ether be an “expansion” or a “new program”** (CAA 2021 section 127)
  - The two IPPS hospitals ***must*** claim training time spent in that hospital or its provider-based clinics.
  - Any non-provider-based clinic time can be claimed by ***either*** IPPS hospital as long as that hospital pays for residents’ salary and benefits for that time.

Case 3: Rural hospital is a CAH

- **Urban/Urban** capped IPPS hospital has one or more residencies
- Rural community is “CMS rural”
- Rural community has a CAH which is **Rural/Rural**
- Rural clinic is in a “CMS rural” location
- How can they get funding? Both DGME and IME?
  - Have >50% training in rural community (rural clinic plus CAH).
  - Get **Both** DGME and IME
  - **RTP could ether be an “expansion” or a “new program”**
  - Likely best financing model is to have urban hospital claim all the rural time.
  - Alternatively, the CAH could make direct claims for residency expenses and get Medicare’s share plus 1%

Case 4: Urban partner is U/R capped and Rural partner is R/R

- **Urban/Rural** capped IPPS hospital has one or more residencies
- **Rural/Rural** IPPS hospital can be capped or GME-naive
- Rural community is “CMS rural”
- Rural clinic is in a “CMS rural” location
- How can they get funding? Both DGME and IME?
  - Get **RTP DGME** funding if >50% training in rural community (rural clinic plus R/R hospital)
  - **RTP must be a “new program”** for the urban/rural hospital to get **IME** payments. No IME increase if an “expansion”. “New program” also helps if R/R hospital is capped.

Case 5: Urban partner is urban/rural and Rural hospital is a CAH

- **Urban/Rural** capped IPPS hospital has one or more residencies
- Rural community is “CMS rural”
- Rural community has a **CAH that is rural/rural**
- Rural clinic is in a “CMS rural” location
- How can they get funding? Both DGME and IME?
  - Get **RTP DGME** funding if >50% training in rural community (rural clinic plus CAH)
  - **RTP must be a “new program”** for the urban/rural hospital to get **IME** payments. No IME if an “expansion”.
  - Likely best financing model is to have urban hospital claim all the rural time.

Case 6: Rural clinic is “FORHP rural” but not “CMS rural”. Partners are U/R IPPS hospital and R/R IPPS hospital.

- **Urban/Rural** capped IPPS hospital has one or more residencies
- Rural community is “CMS rural”
- Rural community has a CAH which is rural/rural
- However, the **rural clinic is “FOHRP rural” but not “CMS rural”**
- How can they get funding? Both DGME and IME?
  - No… unless
    - Use another clinic in a CMS-rural place… or
    - **Make new residency a “new program”** for the urban/rural hospital to get regular additional IME payments. No DGME if not an RTP but IME>DGME so often enough $
  - Best financing model is to have urban hospital claim all the rural time by always paying residents’ salary and benefits.

Case 7: Two urban located hospitals (U/U and U/R) want to start an RTP

with no/minimal rural *located* training.

- **Urban/Urban** capped IPPS hospital has one or more residencies
- **Urban/Rural** capped IPPS hospital has one or more residencies
- How can they get funding? Both DGME and IME?
  - **Yes!** If >50% training at U/R hospital, then it is a qualifying RTP "rural" partner for **IME**. Both hospitals then get **RTP IME only**. There is no rural partner for DGME.
  - Program could be expansion RTP or new program RTP
  - If new program, then the U/R hospital would get IME without needing to consider RTP qualification.
  - The U/U hospital needs program to qualify as an RTP to get IME.

Case 8: Two urban located hospitals (U/R and U/R) want to start an RTP

with no/minimal rural *located* training.

- **Urban/Rural** capped IPPS hospital has one or more residencies
- **Urban/Rural** capped IPPS hospital has one or more residencies
- How can they get funding? Both DGME and IME?
  - N**O. Not as an RTP.** There is no rural partner for DGME and no urban partner for IME
  - However, if this is a **new program**, both hospitals would get **IME** (no DGME) without needing to consider RTP qualification.

QUESTIONS

Lou Sanner, MD, MSPH, FAAFP
Emeritus Professor University of Wisconsin School of Medicine and Public Health
RRPD and THCPD Advisor
lou.sanner@fammed.wisc.edu

For additional information about the RRPD and/or THCPD Program

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