# GME FUNDING CONSIDERATIONS IN RURAL HOSPITALS (CRITICAL ACCESS HOSPITALS)

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# Presentation Overview

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# Acknowledgements


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- NIPDD Participation Sponsored by the Rural Training Track Technical Assistance Program*
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- Additional support provided by:
- The RTT Collaborative
- Peer consultants and participating programs


- Please note: This study is limited by its design as a descriptive study utilizing a convenience sample.

# Background

- Rural Training Tracks have been demonstrated to produce family physicians found to be practicing in rural areas at two to three times the rate of family medicine graduates overall.[1]
- Yet rural training tracks face substantial challenges and most notably financial stressors including in some cases, the solvency of the residency program itself.[3]
- Due to regulatory considerations, hospitals designated as Critical Access Hospitals do not receive graduate medical education funding in a traditional mechanism from Centers for Medicare and Medicaid Services.[4]
- These hospitals are found exclusively in rural areas and are of a limited size.[4]
- These factors result in participation in graduate medical education programs to be more likely found in a 1-2 alternative format, historically referred to in rural areas as a “1-2 Rural Training Tracks”.[5]

# Methods

- The design of this project was a descriptive study utilizing a convenience sample. Both existing Rural Training Tracks programs and interested parties in developing Rural Training Track programs were contacted as potential respondents. Standardized questions were developed and utilized addressing the elements of how graduate medical education reimbursement is occurring in Critical Access Hospital environments where Direct Medical and Indirect Medical Education mechanisms do not apply. Interviews were conducted from volunteers in addition to review of the literature and available information from financial reports and other sources as available, including expert opinion.
- Notably, prior work in the area of identification of graduate medical education programs conducted in Critical Access Hospitals produced a small list of hospitals and only a single hospital which was at the time in 2012 operating a RTT program and receiving funding from the Center for Medicare and Medicaid Services for activities within the Critical Access Hospital.[12]
- For the purposes of this project, examined hospitals were identified either from available public sources denoted by reception of Center for Medicare and Medicaid funding for graduate medical education[13,14] or by direct contact of the participating hospital through the residency program director. Programs thought to be likely to receive such funding were identified from a publicly available database of Rural Training Track programs.[11]

# Findings

- During the course of this initial project, only a single currently operating RTT program was identified to be presently receiving funding from Center for Medicare and Medicaid for educational expenses occurring in a Critical Access Hospital.
- The standardized question of “Does your program receive funding through the Critical Access Hospital from the Center for Medicare and Medicaid Services?” was answered in each other case by the program director as “no” or “unknown”.

# Results

- **Actual or Prospective Cost based reimbursement for RTT-related GME in CAHs**
- **Program** **GME Amount**
- A (2 residents) $ 201,835
- B (4 residents) $0
- C (4 residents) $0
- D (2 residents) $0
- *E (2 residents)* *$80,149*
- 
- Table 1 was generated from an actual cost report in each case with the exception of the budgeted case *(E)* for 2 prospective residents utilizing the described approach with assumptions of 85% time in CAH provider settings and 50% Medicare across all cost centers. [10,15,16]

# Results

- One approach to a formula could be suggested as follows:
  - (cost center) * (resident time) * (% Medicare) = net % of residency costs paid by Medicare for that cost center
  - Summation of these cost centers = net % of residency costs paid by Medicare
  - Note: cost centers may include the family practice clinic if a provider-based clinic of the CAH (allowable cost center)

# Next Steps

- This additional work as based on this project is presently supported by an interest in further investigation within the context of the RTT Technical Assistance Program.[11]
- It is anticipated to include an IRB approved study in the form of a survey of program directors examining the identified barriers to progressing toward the goals of effective funding of rural family medicine graduate medical education in settings such as Rural Training Tracks operating in Critical Access Hospital environments.

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# Questions/
# Comments for Discussion