Sustainable RTT Program Design

Understanding the requirements

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Key questions for new rural programs

- Is it possible to do in our community with available urban partner(s)?
- Can it be done well?
- Attractive to faculty, applicants and patients?
- Financially viable for sponsors and stakeholders?
- Stakeholder commitment?

Features of sustainable RTTs

- **Rural physician leadership** and commitment
- **Attractive rural** practice/living community and **strong urban** partner(s)
- **Stakeholder commitment** (hospital(s), practice group(s), other local and state entities)
- **Sufficient clinical resources** for training rural and urban
- **Sufficient financial resources** available to initiate and sustain program. Stakeholder "acceptable loss" or "acceptable risk" given many uncertainties.
- **Design that complies with rules:** ACGME regs, Medicare GME rules

Key decisions

- Timeline (included timeline to decide)
- Initial program director and likely faculty
- Family Medical Practice at rural site
  - When do RTT residents actually start seeing patients at rural site?
- Design that takes into account ACGME and Medicare rules
  - … AND what kind of practice and residency you want!

Rest of this talk

- Finances – matching income source to expense category "clinical" vs "academic"
- RTTs – Medicare definitions
- New programs vs expansions
- Medicare regs vs ACGME rules
- RTT PD and core faculty requirements
- Hospital issues
- The rural FMP – design the practice you want!

Finance issues: Sources of income

- Clinical practice
- Medicare GME via hospital claims
- Sometimes available:
  - Medicaid GME (variable)
  - Other state/university support
  - Teaching Health Center grants
- Local health system acceptance of ongoing loses

Finances: Income sources cover what?

- Clinical income (residents providing care) basically pays for:
  - The residents' share (like any provider) of the expense of running a clinical practice (with some "inefficiency" calculation)
  - The time physician faculty spend directly supervising care in clinic and the hospital.
  - NOT the residents' salary and benefits

Finances: Income sources cover what?

- Nonclinical income sources needed to cover
  - Startup costs:
    - planning, approvals, recruiting PD and faculty, starting practice, building/redesigning space, 1st year with residents.
  - Ongoing costs:
    - Residents' salary and benefits
    - "Infrastructure costs":
      - Program and other faculty time for administrative and academic activities
      - The staff costs, space, etc. needed to run the residency (not run the clinic)
      - Some adjustment for "inefficiency" in the residents' practice (more nursing, inefficient room use, providers not in clinic every day, turnover with graduation)

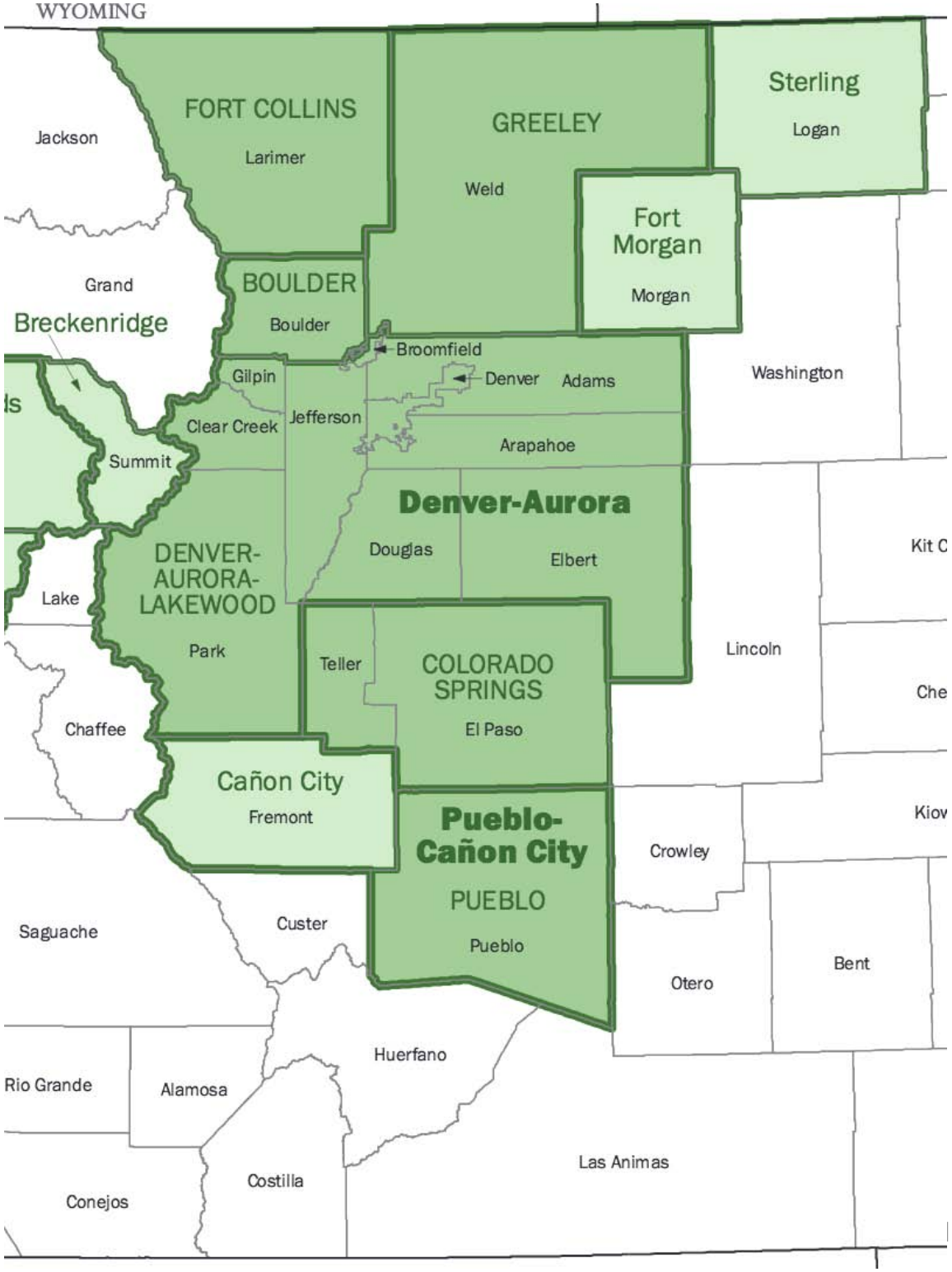
Finances: Nonclinical income

- Traditionally the role of Medicare GME income has been to cover ongoing (not startup) residents' salaries plus benefits and nonclinical (non-billable) infrastructure costs.
- What is needed?:
  - Current S&B of residents ~$75,000/yr per resident
  - This approximately doubles when infrastructure costs included but considerable variability especially for small programs.
  - So net need is $120,00-160,000 per year per resident depending on size of program. (2-2-2 RTT ~ $150,000)
  - 2012 US hospital data (Graham Center analysis) Medicare GME payments:
    - 25th percentile total GME $ 73k, IME $ 45k, DGME $ 24k
    - 50th percentile total GME $118k, IME $ 78k, DGME $ 39k
    - 75th percentile total GME $159k, IME $106k, DGME $ 53k

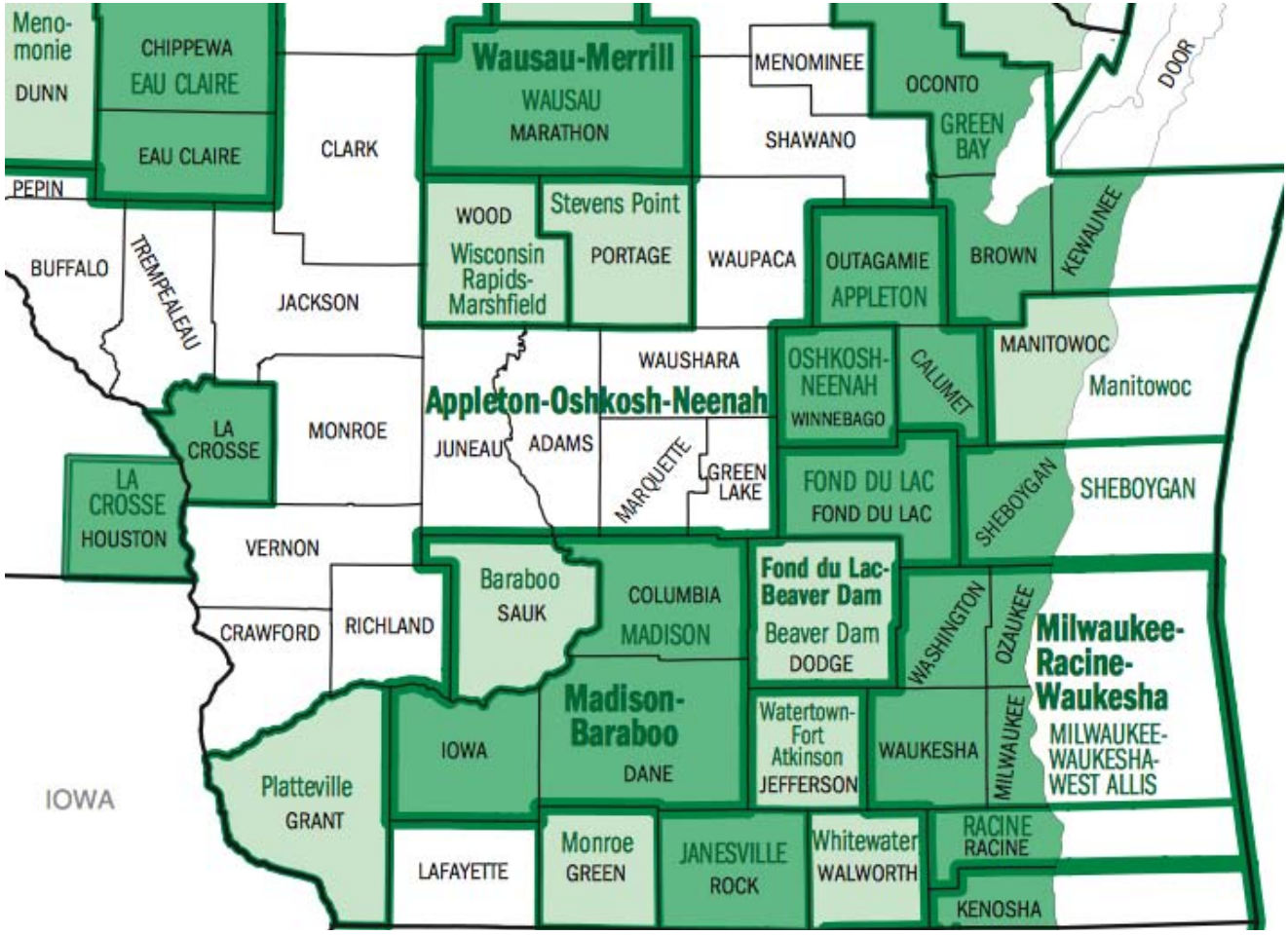
Medicare GME – focus on RTTs

- Medicare definition of an RTT:
  - Residency program where >50% of training occurs in "rural" community(ies)
    - For Family Medicine that is >= 18 months.
  - "Rural" meaning "not in a metropolitan CBSA"
  - Rural training can be in a rural hospital(s) or in rural non-hospital settings
  - Some RTTs have NO rural hospital

Core Based Statistical Areas (CBSA)- Colorado Feb 2013

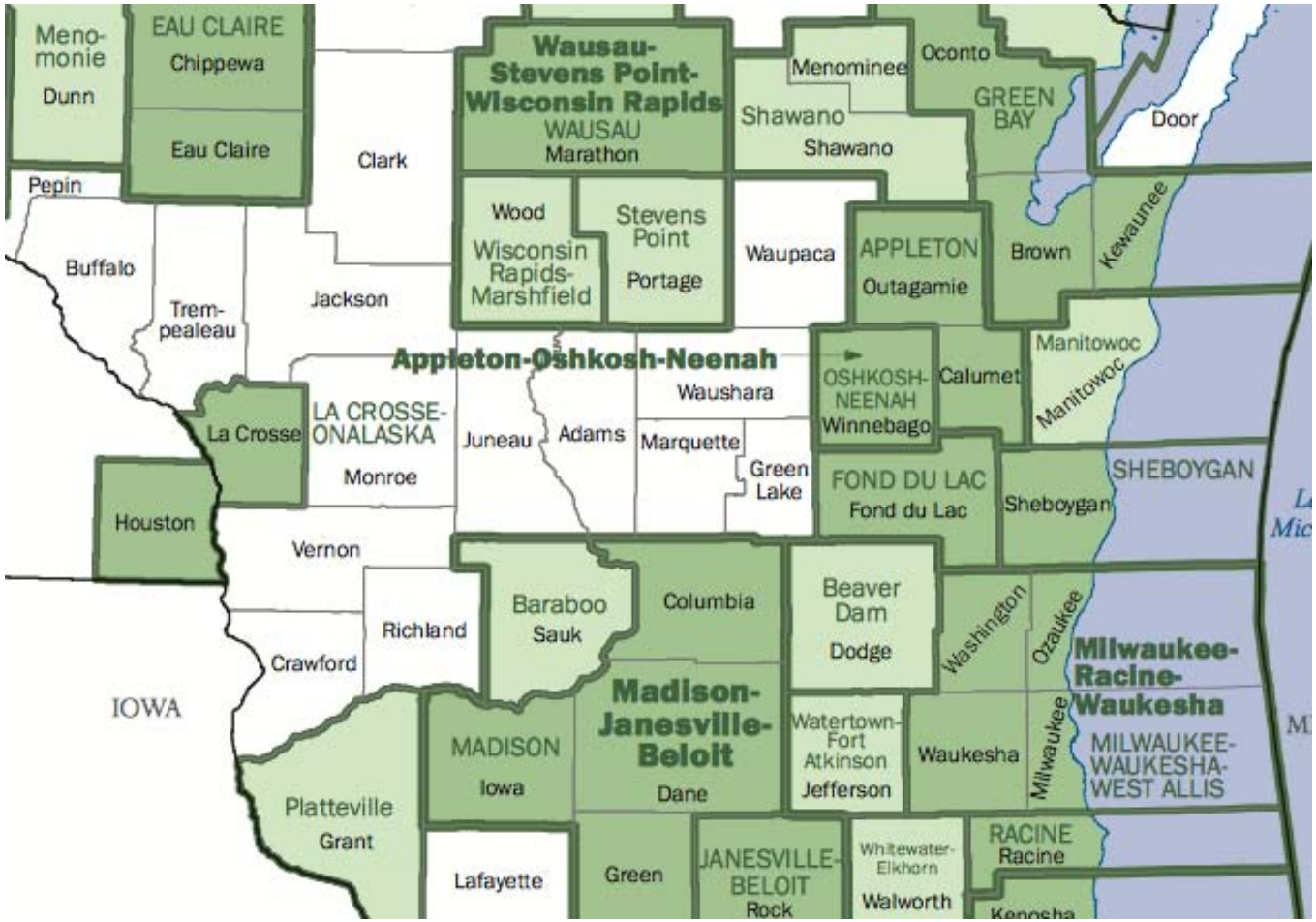


Core Based Statistical Areas (CBSA)-SE Wisconsin June 2003



Core Based Statistical Areas (CBSA)- SE Wisconsin Feb 2013

(notice what happened to Green County in southern WI)



RTTs – the urban hospital(s)

- Urban hospitals build a separate "RTT cap" for getting paid above their current cap
  - "Cap clock" starts when first RTT resident is claimed by urban hospital.
  - Cap is set using the 3rd full year of claims for RTT residents by taking the largest class (PGY-year) and multiplying by the length of the program.
    - Some adjustment made depending on which hospitals (e.g. rural vs urban) have been claiming RTT residents for the 3 years.
    - If no rural hospital involved then an urban hospital could potentially claim all 3 years with a letter of agreement with rural ambulatory sites.
  - RTT cap is specialty specific
    - If the urban hospital want to participate in another Family Med RTT they don't get to add to this RTT cap
      - Want to start many FM RTTs? You have 3 years to implement all of them…
    - If the urban hospital wants to participate/sponsor a new RTT in another specialty then the cap reopens.

Medicare GME – new programs?

- New programs vs expansions of old programs.
  - New program must meet 3 criteria:
    - New program director (not same as current program director of another program – e.g. the urban residency).
    - New (separate) core faculty. Can't count same people as core faculty in both programs.
    - New (separately recruited) residents.

RTTs and the "new program" rule

- So does the "new RTT" have to meet all the rules for a "new program" for hospitals to be paid for these new residents?.
  - For urban hospital maybe not
    - RTT definition rules (and being "first" RTT for the urban hospital) appears to trump "New vs expansion" rules.
  - For rural hospital
    - "new vs expanded" rules appear to have primacy.
- Miechal Lefkowitz will have weighed in…
- So an RTT could have same PD as urban program and still the urban hospital would get paid while this would cause the rural hospital to not get paid?

Intersection of ACGME and Medicare rules

- Medicare cares:
  - That the program be ACGME accredited
  - That there is a program director (PD)
  - That there are designated "faculty"
  - Where the residents train
    - To meet RTT rules
    - Which hospital must claim resident time, which hospital can't and which rotations can be claimed by whichever hospital pays the residents' salary and benefits.
  - Does program meet "new program" definition
- Medicare doesn't care about
  - the ACGME job description or any practice limitations on PDs or faculty.
  - We adopt the ACGME term "core faculty" to attempt to meet Medicare "new program" rules.

Intersection of ACGME and Medicare rules

- ACGME cares:
  - that the program continues to meet many regulations to remain ACGME accredited
  - about the actual qualifications and limitations on direct patient care for program directors and core faculty.
  - If "program" meets ACGME definition of a "track" or a "program" or an "additional/alternative FMP site"
- ACGME doesn't care about
  - how its rules (e.g. alternative training tract definitions) do or don't fit with Medicare rules.
  - If a program is considered new or an expansion by Medicare
  - how programs are funded

Different definitions of term "Track"…

- Medicare:
  - Only uses term for RTTs
  - >50% training time in rural area (Medicare definition of "rural")
- ACGME:
  - Uses term is "proposed program" shares 20 months rotations with core program
  - "Track" then NOT a new program
  - Otherwise "proposed program" is a ACGME "new program" (separate program)
- ACGME and Medicare thus use OPPOSITE definitions

Different definitions of term "New program"

- Medicare:
  - The 3 rules:
    - New (separate) PD
    - New (separate) faculty
    - New (separately recruited/matched) residents
- ACGME:
  - If "proposed program" has <20 months in common with current program then this is a new program
  - Otherwise ACGME "track" or "alternative training site"
  - ACGME "1-2 RTT" rules are stated in "track" section but it is clear a "1-2 RTT" is not an ACGME track
- You can thus be
  - ACGME "new program" but Medicare "program expansion"
  - ACGME "alternative training site" but Medicare "new RTT program"

ACGME focus on PD and faculty

- Program director
  - Qualifications.
    - 5 years minimum experience in Family Medicine
    - 2 years minimum as core residency faculty
  - Limitations on practice
    - 30% maximum patient care without residents
- Core faculty
  - How many needed
    - One per 6 residents (not counting the PD)
  - Limitations on practice
    - 40% maximum patient care without residents

ACGME PD and core faculty time allocation

- **Unclear about "billable" vs "not billable" activities** – i.e. potentially core faculty could see patients four half days a week and precept the other six:

program director	Minimum	Maximum
patient care without residents	some ?	30%
admin/academic/precepting	70%	almost all?
core faculty	Minimum	Maximum
patient care without residents	some ?	40%
admin/academic/precepting	60%	almost all?

- I prefer specific guidelines about budgeting "non-billable" academic/admin time. For core (3 full year) programs (minimum size 4-4-4) consider:

program director	Minimum	Maximum
patient care without residents	10%	30%
precepting	10%	30%
admin/academic	**50%**	80%
core faculty	Minimum	Maximum
patient care without residents	20%	40%
precepting	10%	40%
admin/academic	**25%**	70%

- Note budget support needed!

ACGME PD and core faculty time allocation

- **For small programs (e.g. 2-2-2 RTTs)**

program director	Minimum	Maximum
patient care without residents	10%	30%
precepting	10%	50%
admin/academic	**30%**	80%
core faculty	Minimum	Maximum
patient care without residents	20%	40%
precepting	10%	40%
admin/academic	**20%**	70%

A **30%** minimum admin/academic time for the rural PD presumes that there is a LOT of support coming from the core urban program and the DIO to fulfill administrative and recruiting and curriculum development functions for the RTT PD.

- Note budget support needed!

What does this mean for rural programs that want to be considered "new" programs?

- Program director
  - Limitations on personal practice of 30% time often too costly or not desired by rural-based physicians
  - Trying to make the program cost efficient by having the rural PD do most of the precepting distorts the teaching program and limits the roles of other faculty
  - Many small RTTs call the rural physician lead the "site director" (not a defined AGGME or Medicare term) and basically count that physician as core faculty.
  - Risk running afoul of the "rules for new vs expanded program" and losing rural hospital GME funding

What does this mean (continued)

- Core faculty
  - If you can't count the rural lead physician as one core faculty then this adds to number of core faculty needed
  - Issues with defining "separate core faculty" from the urban residency.
  - Issues of when to count the RTT residents as being "on site" in rural community to calculate number core faculty needed
- Relief from ACGME?
  - We would like practice time limitations eased for RTTs

Hospital issues – and relief?

- Cap clocks and PRA setting
- Critical Access Hospitals
- Sole Community Hospitals

PRA setting and Cap Clocks

- Has your hospital ever had a resident (any specialty including podiatry and dental) do a formal rotation in the hospital or it's provider based clinics – even if no $ spent and not claimed on a cost report?
  - If no – great! You set your PRA when the first resident dose a rotation and your Cap Clock starts when the first resident from a new program does a rotation.
  - If yes (or maybe) then trouble. At risk for "zero PRA" and/or "tiny cap"
- Relief? The "Ribble bill"…

Critical Access Hospitals (CAH)

- The double whammy:
  - **No other hospital can claim** resident time at a CAH or the CAH's provider-based clinics
  - **CAHs get low reimbursement** when they claim residency expenses
    - It's 1983!
    - No DRGs, no caps, no PRA, No DGME, No IME
    - Its all about actual costs claimed for patient care
    - Medicare pays its "share" plus 1%
    - The math looks like DGME and there is **no IME**
    - Medicare percent of care at a CAH often lower than urban due to obstetric volume

Critical Access Hospitals (CAH)

- Proposals to fix this (no draft legislation yet…)
  - Allow the CAH to decide each year if it wants to be treated one of two ways:
    - As an "ambulatory clinic site" (for GME purposes only) thus allowing other hospitals to claim time residents spend at the CAH, or..
    - As a hospital that can make it's own residency expense claims on cost report and get BOTH
      - Medicare's share plus 1% (the math equivalent of DGME)
      - IME s calculated based on DRG equivalents
    - Neither approach actually fixes the "low Medicare share" issue
  - Fund rural residencies within the Medicare GME funding stream (entitlement process) but use a **national per resident payment** calculation that does not discount based on Medicare's share of care.

Sole Community Hospitals (SCH)

- DRGs paid either at
  - Federal rate or
  - "Hospital Specific Rate" (HSR) whichever is higher year-to-year.
- DGME payments:
  - same as other IPPS hospitals
- IME:
  - Get IME for Medicare Advantage (MA).
  - Only get IME for non-MA care if they are being paid the federal rate for DRGs
- Proposals to fix:
  - Pay SCHs IME regardless of base DRG rate

The Rural FMP – thinking beyond ACGME and Medicare regulations

- Consider the perspectives of:
  - **Physician faculty and the PD**. What job mix will facilitate recruitment and retention?
  - **Residents and applicants**. What is an attractive practice and faculty mix in which to work and learn?
  - **Patients**. How attractive is the rural FMP as a medical home? What % of visits are with providers who are not leaving (faculty physicians and PA/NPs)? How do you deal with resident graduation and turnover?
  - **Staff**: How to you support a practice where "every day is different", learners are core practitioners and providers are not always in clinic every day?
  - **The local health system**. What is a reasonable "production and performance" expectation for a clinic with residents? For faculty?
  - **The community**. How involved is the community in understanding and guiding the residency practice over time?

The Rural FMP - the math of visits, precepting, academics and administration. Intelligent design?

- **It takes at least one core family medicine faculty above ACGME minimums** to manage the basic weekly tasks (precepting, hospital supervision, personal practice, academics, admin) in a 2-2-2, 4-4-4, 6-6-6 residency.
- **"Academic/admin" time generally consumed by "inbasket management"** unless **this** time is taken out of patient care.
  - Does your practice recognize "direct" vs "indirect" patient care time?
- **Time spent supervising care in the hospital** has to be part of the basic math in designing faculty jobs
- **"precepting comes first"** – if too few faculty (by design or not) then personal practice and academic/admin time go away. Then faculty go away…

Impact of at least one additional core faculty above ACGME minimum

- ACGME minimum:

			Core faculty job 1/2 days per wk			
Residency size	PD?	ACGME minimum	Patient care (without res) *	Precepting in clinic	acad/adm in	% visits by faculty
2-2-2	1	1	2	5.5	2.5	28%
4-4-4	1	2	1	6.5	2.5	14%
6-6-6	1	3	0.5	7	2.5	8%

- Add 1 (2 if 6-6-6) above minimum:

2-2-2	1	2	3	4.5	2.5	55%
4-4-4	1	3	3	4.5	2.5	37%
6-6-6	1	5	3.3	4.2	2.5	39%

- My clinic:

4-4-4	1	7	5	2.5	2.5	60%

- * should include "nondirect" patient care time

In summary

- Understand ACGME and Medicare regulations in the overall design of your program and practice
  - Implications about $
  - Implications about the PD and faculty
- Design a FMP that has the desired mix of faculty, APPs and residents seeing patients. Build THAT FMC.
- Budget start-up and ongoing expenses in a sustainable way supported by sponsors and stakeholders
- Help change the rules!