

**DRAFT: Pilot Program to Expand Graduate Medical
Education in Rural and Medically Underserved Areas for
Primary Care**

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LIST OF ABBREVIATIONS

CMS	Centers for Medicare and Medicaid Services
DHMH	Department of Health and Mental Hygiene
DME	Direct medical education
GME	Graduate medical education
HPSA	Health professional shortage area
HSCRC	Health Services Cost Review Commission
IME	Indirect medical education
MUA	Medically underserved area
ORHP	Office of Rural Health Policy
PQI	Prevention quality indicator
SHIP	State Health Improvement Process
TCOC	Total Cost of Care

INTRODUCTION AND BACKGROUND

Graduate medical education (GME) refers to medical training following the completion of undergraduate medical education. GME costs include both direct medical education (DME) and indirect medical education (IME). DME costs are those directly incurred in the operation of teaching activities and include the actual salaries and benefits of residents, faculty supervisory expenses, and allocated overhead. IME expenses are the additional costs incurred because of the teaching function, such as higher costs for ancillary services and other treatment inefficiencies that occur as part of residency training, staff and supplies resulting from the higher acuity of patients treated at teaching hospitals, and the early adoption of new technology to support teaching and research.

When the Maryland Health Services Cost Review Commission (HSCRC or Commission) began setting rates in 1974, it began funding GME on an all-payer basis; i.e., all payers contribute to GME through hospital reimbursement rates. GME funding is part of a hospital's total rate structure. This amount is carried forward annually and adjusted for a number of factors, including inflation and population changes. If a hospital wants to alter the amount of GME funding in its rates, HSCRC policy requires a full rate review. Currently, there is a moratorium on full rate reviews.

Effective January 1, 2014, Maryland entered into a new All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS) with a triple aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. The Agreement required the state to convene a Workgroup on innovations in medical education and develop a blueprint for the improvement elements necessary to sustain health and transformation initiatives in Maryland. To meet this charge, the Maryland Department of Health and Mental Hygiene (DHMH) convened the Innovations in Graduate Medical Education Workgroup in 2015. In its January 2016 report to CMS, the Workgroup recommended that the HSCRC consider a partial rate review—rather than a full rate review—for hospitals seeking funding to make changes to or establish new residency programs.¹

Due to concerns about the adequacy of GME funding in rural and medically underserved areas (MUAs) specifically, other stakeholders have also proposed that the HSCRC allow for partial rate reviews that focus only on rates related to GME. In consideration of these proposals, the purpose of this report is to provide background information and guidance regarding the criteria the HSCRC will use to evaluate a hospital's application for additional GME program funding.

¹ Maryland Department of Health and Mental Hygiene. (2016). *Report to Centers for Medicare and Medicaid Services: Innovations in Graduate Medical Education*. Retrieved from <http://dhmh.maryland.gov/GME/SiteAssets/SitePages/meetings/GME%20Report%20-%20Sent%20to%20DHMH%20-%2011-30-2015.pdf>

ASSESSMENT

Health Measures in Rural Areas

In March 2016, the Primary Care Office within DHMH published the *2016 Primary Care Needs Assessment*.² The *Primary Care Needs Assessment* is based on the integration of two health data tracking methods: prevention quality indicators (PQIs) and the State Health Improvement Process (SHIP). PQIs are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for ambulatory care sensitive conditions, or conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The SHIP includes 38 measures that represent clinical and non-clinical determinants of health. In the *Primary Care Needs Assessment*, each PQI and SHIP measure is ranked by jurisdiction from 1 to 24 and then entered into a matrix. The matrix has an ordered ranking of rates and percentages for each jurisdiction. Of the 18 jurisdictions with rural areas, 50 percent are listed in the third and fourth quartiles of the health indicator analyses. Specifically, Allegany, Dorchester, Kent, and Washington Counties demonstrated the lowest health outcomes.

Health Professional Shortage Areas

The federal government uses the shortage designations of health professional shortage areas (HPSAs) and MUAs to identify areas and populations with insufficient health care resources. HPSAs have a shortage of primary medical care, dental, or mental health providers. The federal methodology establishes three types of geographic units as HPSAs: whole counties, multiple counties, or sub-counties (such as census tracts based on established neighborhoods).³ The methodology also identifies certain populations with shortages, including low income, homeless, Medicaid, and seasonal tourists, using specific population data. The entire population or only a certain portion of the population in a county may reside within or be designated as experiencing shortages of health professionals based on federal criteria. Certain types of facilities—such as prisons, mental health hospitals, federally qualified health centers, or other public or nonprofit facilities—are also eligible to be designated as HPSA facilities. According to the *Primary Care Needs Assessment*, Maryland had 32 primary care HPSA designations covering 791,181 residents (14 percent of the state’s population) in 2015. There were 26 dental HPSAs encompassing 522,034 residents and 35 mental health HPSAs encompassing 1,333,806 residents.

MUAs are federally designated locations or population groups that have a shortage of primary care resources that are based on four criteria: the infant mortality rate, the percentage of the population living in poverty, the percentage of the population over the age of 65, and the

² Maryland Department of Health and Mental Hygiene. (2016). *2016 Primary Care Needs Assessment*. Office of Primary Care Access, Prevention and Health Promotion Administration.

³ U.S. Department of Health and Human Services. *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations*. Retrieved from <http://www.hrsa.gov/shortage/>

population-to-primary care provider ratio. As of 2015, there were 46 MUAs in Maryland covering more than 974,000 Maryland residents.

PRIMARY CARE

The HSCRC seeks to increase the number of primary care providers in rural areas through supporting graduate medical education. This policy aims to support GME programs that train residents in preventive care, health maintenance, and chronic care and disease management. GME programs should support training in the following practices: family medicine, internal medicine, geriatric medicine, and pediatric medicine. Additionally, residents should receive training outside of the hospital setting.

POLICY OUTLINE

In light of the shortage areas and the stakeholder proposals described above, the Innovations in Graduate Medical Education workgroup recommended that the Commission consider partial rate reviews for GME in certain circumstances. In this policy outline, we have defined criteria for hospitals seeking a partial rate review for GME. We also suggest that HSCRC engage with one hospital to pilot a physician shortage area GME partial rate review over the course of five years.

Criteria for GME Partial Rate Review

GME partial rate review will be limited to DME costs; IME will not be considered in GME partial rate reviews.

In order to qualify for a GME partial rate review, staff proposes that a hospital must meet the following four criteria:

1. Located in a state-designated rural area

Maryland has legislatively designated 18 of its 24 jurisdictions as rural.⁴ This includes Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester Counties.

2. Located in or near an MUA or HPSA

Portions of all 18 counties that Maryland designates as rural are partial or full MUAs.

⁴ This is in contrast to the five full counties and six partial counties that are designated as rural by the federal government. In order to meet the state-specific demands of rural primary care physicians, a hospital must be located in a state-designated rural jurisdiction.

Parts of 13 Maryland designated rural counties are also HPSAs. This includes Allegany, Caroline, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, and Worcester Counties.

3. Hospital not part of a Maryland health systems with existing GME programs

Hospitals requesting partial rate review must be adequately separated from healthcare systems with existing GME programs so as to fill a gap in care accessibility.

4. Quality and population health indicators identify improvement needs

To qualify for a GME partial rate review, quality and population health indicators should identify improvement needs in the hospital's jurisdiction. Hospitals should reference the Primary Care Needs Assessment report issued by the Office of Primary Care Access.

Additional Requirements

In addition to the four criteria described above, hospitals seeking for a GME partial rate review must also provide substantive information to identify:

- Needs justification
- Description of how the program would enhance the triple aim
- Plan for physician retention

Needs Justification

In order to appropriately utilize limited funding, the HSCRC will require the hospital to submit an assessment and justification of the need for the GME program as part of the partial rate review application. Such justification should include population health metrics and an estimate of the distance from the nearest hospital with an existing GME program. The hospital should also provide insight into provider shortages. The HSCRC will issue further guidance on the specific measures that should be addressed.

Triple Aim

The new All-Payer Model Agreement has a triple aim of enhanced quality, reduced costs, and improved health outcomes. The applicant must describe how the proposed GME program would enhance the triple aim. Particular attention will be paid to care coordination and total cost of care containment. The applicant should also describe how provider training in the program will address population health.

Retention

GME may impact where physicians practice and the types of populations they serve. Data from the American Medical Association Physician Masterfile shows that 11 percent of family medicine graduates practice within five miles of their program and 22 percent practice within 25

miles.⁵ To meet the demands of the changing workforce and population, it is important for hospitals to be able to show a retention plan for the physicians that they are educating. Examples of retention efforts include, but are not limited to, student loan assistance and financial incentives to practice in high-need areas for a designated period.

Measuring Success

Continued funding and additional consideration of GME partial rate reviews outside the pilot will be contingent on the ongoing success of the GME program. The HSCRC will consider various factors in evaluating the successes of the GME program, including the following:

- **Physician retention** will be a primary consideration. A thorough reporting of the successes of the hospital's retention plan will be required for continued funding.
- **Health status** improvement is a part of the Triple Aim. It will be important to track improvements or declines in population health through PQIs, readmissions, potentially preventable conditions/potentially avoidable utilization, and other measures.
- **Care coordination** efforts by the hospital will also be monitored. As hospitals continue to develop infrastructure to support care coordination efforts, the HSCRC expects the residency program to include training for physicians in utilizing care coordination tools and methods to best care for their patients.
- **TCOC performance** will be monitored. The All-Payer Model Agreement includes TCOC "guardrails" to ensure that cost shifting to the non-hospital side does not undermine hospital savings. HSCRC will monitor the changes in GME funding and its potential impact on total cost of care.

HSCRC will require the hospital to submit an interim report as well as a final report at the end of the fifth year of the program, detailing the impact the GME program has had on the community and its performance on the above criteria. The HSCRC will issue further instructions as the reporting deadline draws near.

⁵ Fagan, E. B., Finnegan, S. C., Bazemore, A. W., Gibbons, C. B., & Petterson, S. M. (2013). Migration after family medicine residency: 56% of graduates practice within 100 miles of training. *Am Fam Physician* 88(10), 704. Retrieved from <http://www.aafp.org/afp/2013/1115/p704.html>