VHHA Testimony to Administration's Provider Assessment Work Group
10/28/15

Healthcare Financial Realities

- Our country's health care system is complex and heavily regulated. The combined effect of government funding cuts, care mandates, reimbursement inadequacy and other statutory and regulatory requirements has left providers in a financial predicament.

- The financial forecast we discussed at the last meeting made this case very clearly. There is no silver bullet to solve the cumulative impact of those actions. But there are steps that can be taken by state policy makers to mitigate the looming harm to the many good-paying jobs, major economic contributions, and critical public health caretaker role provided by hospitals and health systems.

- Accessing available federal dollars to offset some of the Affordable Care Act-related cuts is not a miracle cure. It would, however, stem the bleeding at many Virginia hospitals operating in the red due to government decisions that have eroded providers' stability.

- There is also a strong case to be made that doing so is fiscally prudent for the Commonwealth. Virginia is unnecessarily spending $15 million a month in general funds it wouldn't have to if the Commonwealth recaptured its own tax and healthcare dollars from Washington. Declining to do so means Virginia is foregoing $200 million each month. The state budget math couldn't be more compelling.

- Virginia health care providers did not champion the Affordable Care Act, but it is the system we have at this point and we must manage in the current reality. We remain optimistic that policymakers of good will who are rightly focused on jobs and the economy recognize what a significant cornerstone hospitals and health systems are in communities across Virginia.

- We are confident elected leaders can craft a plan that protects the Commonwealth's finances and hospitals and health systems want to be part of the conversation about how we can help facilitate that.

On Assessments

- A potential assessment on health care providers has significant financial implications for hospitals and experience in other states suggests that it exposes providers to the risk that revenues can be diverted for uses unrelated to the Medicaid program and health system improvements.

- Accordingly, careful consideration should be given to structural components needed to ensure that the proceeds of an assessment remain dedicated to attaining agreed upon policy goals. Absent such safeguards we cannot support imposing an assessment on hospitals, or other providers for that matter.

- Where assessments have been in place for extended periods and have operated in a fashion that is "mutually beneficial to the [state] / Commonwealth and affected health care organizations"* they are governed by separate enabling legislation and contain several key provisions which:
    a. Detail the maintenance of effort requirements (in terms of supporting the existing Medicaid program and base-line payment policy) that if violated void the assessment program;
    b. Specify the level and basis for the assessment;
    c. Define the policy goals or purposes to which the additional resources are applied; and
    d. Addresses the state administrative costs, but otherwise does not divert the assessment proceeds to other purposes.

- For the current Medicaid program, we think there are three overarching goals when considering a potential hospital assessment program:
    a. "Preserving access to essential health care services (e.g., trauma programs, obstetrical care) throughout the Commonwealth"* by addressing longstanding hospital Medicaid payment shortfalls;
    b. Strengthening our rural hospitals; and
    c. Helping address our future healthcare workforce needs by "supporting the indigent care and graduate medical education costs at hospitals in the Commonwealth"*.

- However, absent the legislative parameters highlighted previously none of these goals are assured and we cannot support imposing an assessment on hospitals.

** Quotes from study language framing the Assessment Advisory Group's work.*

Conclusion

- At the end of the day, we hope the advisory group and political leaders will approach the challenges confronting our health care system with "a spirit of openness and pragmatism".

- First and foremost, that should include serious consideration of a Virginia plan for extending cost-effective coverage to low-income working Virginians. Finding a path forward on expanding coverage is the single most impactful policy lever available to the Commonwealth.

- A continued strong health care system and better health for every Virginian is what health systems are committed to. There is no easy, silver bullet solution. But there are constructive steps we can all take.

Provider Assessment Work Group
VHCA Public Comments
October 28, 2015

Good morning, I am Steve Ford, Senior Vice President of Policy and Reimbursement, offering comments on behalf of the Virginia Health Care Association. VHCA represents the interests of over 270 nursing and assisted living facilities in the Commonwealth. We're proud of our role as Virginia's largest association representing long term care.

We have significant concerns about the implementation of a provider assessment on nursing centers. Some of our members have experience with provider assessments because of their operations in other states. From those experiences, we have identified several concerns with this approach to Medicaid financing for nursing centers.

First, it is very difficult to design a provider assessment that will result in a sustained increase in revenue across the providers VHCA represents due to federal program design rules and differences in provider circumstances, such as Medicaid utilization levels. Implementation of a provider assessment will likely create winners and losers for our nursing centers, disadvantaging some over others. To the extent some portion of the assessment is utilized for purposes other than rate enhancement back to those centers paying the assessment, the number of providers disadvantaged only increases.

In other states, our members have also experienced, over time, that revenue from a provider assessment gradually transitions from enhanced payment to assessed providers to a substitution of what would have been state funding of

the services provided absent the assessment. This traditionally happens in times of revenue shortfalls or slow growth when there are competing priorities for funding and not enough revenue to meet all the needs of the state. In these situations, the added revenue from the provider assessment allows the state to reduce its Medicaid funding obligation relative to what it would have been absent the assessment. Thus, after these budget pressures persist, reimbursement levels often revert back to the growth curve experienced prior to the assessment, despite a portion of that same reimbursement level now being self-funded by providers.

While policymakers may have good intentions on initial program design through language protecting the revenue from the provider assessment as "enhanced" funding, these intentions are often subsequently undermined by the aforementioned budget realities and competing priorities. Keep in mind that even a duly promulgated regulation, one of the strongest mechanisms available to guarantee policy adherence, can be subordinated by the budget.

Finally, VHCA is concerned that funding mechanisms would not remain intact as federal budget pressures continue to increase. The federal government has been active in regulating this Medicaid funding practice in the past several years, and there are continuing discussions that these non-standard funding methods remain under the microscope as federal budget pressures mount.

For these reasons, VHCA cannot support the application of a provider assessment on our member nursing facilities. Thank you for the opportunity to comment.

Provider Assessment Work Group
VAHP Position Statements

According to the budget language, this work group was charged with reviewing information to consider a possible hospital provider assessment arrangement using 6 specific conditions when developing a recommended proposal.

As we heard at the first meeting, as of 2014, 39 states have a hospital provider assessment used in many cases to fund Medicaid and/or to provide non DSH payments to supplement the cost of hospital care for that state's most vulnerable citizens.

As of 2014, only 12 states had any type of Managed Care Organization (MCO) provider assessment. These states are mainly in the southwest. If health insurers are subjected to a provider tax, all HMOs doing business in Virginia must be assessed, even those that are not contracting with Medicaid.

The Virginia Association of Health Plans, on behalf of our 10 member health plans who provide most Virginians with health insurance coverage, are opposed to any proposal that would include assessing HMOs because:

- If HMOs are charged a provider tax, Virginia will be applying this tax on top of the other taxes like the ACA mandate health insurance tax to fully insured individuals and small businesses who can least afford it.

- Since DMAS requires health plans participating in Medicaid to be licensed in Virginia as HMOs and since rates paid to those health plans must be actuarially sound, the Commonwealth would be paying any tax assessed on managed care Medicaid services for approximately 750,000 Virginians. The Commonwealth would be simply shifting expenditures from one part of the budget to another.

- In states that have provider taxes for entities other than HMOs, in many cases that state is able to use all or most of the funds derived from the tax as well as the federal match portion, not just shuffle money around.

In conclusion, VAHP recommends that the work group focus on what was requested in the budget language – exploring the opportunities for a hospital provider tax that addresses perceived inequities within the hospital community.

LeadingAge™
Virginia

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Comments to the Provider Assessment Work Group
October 28, 2015

Thank you for the opportunity to comment today. At this time, LeadingAge Virginia (formerly VANHA) does not believe that Virginia's nursing homes should be included in a provider assessment program. The association has three major points to support this position.

#1) Nursing homes are currently working through the implementation of the new fully prospective price-based payment methodology that impacts their reimbursement payments.

First, during this difficult economic time, the Virginia nursing homes reimbursement payment system was changed to a fully prospective price-based payment methodology. Over many years, DMAS and the provider association groups worked together to implement this complicated system, which would assist the state in a cost savings, but not without a financial impact on the nursing homes.

The proposed Nursing Facility Price-Based Payment Methodology includes the following:

- Fully prospective operating rates for direct and indirect costs;
- Based on costs from a base year inflated to the rate year;
- Adjusted for regional cost differences;
- Direct costs are "neutralized" using raw case mix rather than normalized case mix;
- The rate for direct costs is based on an adjustment factor of 105% of the Medicaid day weighted median for freestanding nursing facilities by peer group and the rate for indirect costs is based on an adjustment factor of 100.7% of the Medicaid day-weighted median for indirect costs for freestanding nursing facilities by peer group;
- There is a price-based spending floor; and

- The direct rate component is adjusted on each claim by the resident's current Medicaid RUGs score (similar to the determination of Medicare rates)

#2) Many residents within nursing homes that are both dually eligible for Medicaid and Medicare are currently enrolled currently in the Commonwealth Coordinated Care program that is a new program intended to be a single program to coordinate delivery of primary, preventive, acute, behavioral, and long-term services and supports.

This program has a major impact on a nursing home's reimbursement. Unfortunately, it is has had a lot of "kinks to work out" and nursing homes have been negatively impacted with the coordination of services and reimbursement. In some cases, nursing homes are currently waiting for reimbursement reaching $500,000 plus dollars. This program will not be extended beyond December 2017.

Beginning July 1, 2017, DMAS will implement a single mandatory Medicaid MLTSS program. Under this single MLTSS program, the majority of the remaining fee-for-service populations, including those eligible for the CCC program, dual eligible members currently not eligible for the CCC program, and individuals receiving long term services and supports either through a waiver or who reside in a nursing facility, will be mandatorily enrolled in managed care. In December 2017, when the CCC program ends, DMAS will enroll these individuals into the MLTSS program on a phased-in basis.

Nursing homes are currently working through the impact of the implementation priced-based system and a range of managed care programs that impact their reimbursement rates. Implementing a provider assessment in addition to these programs could have a tremendous negative impact on their budgets and could impact the overall quality of care provided to the residents.

#3) Private pay nursing homes would be required to pay the assessment without any reimbursement.

The implementation of a provider assessment program would need to be broadly applied thereby impacting nursing homes that do not currently participate in Medicaid. Therefore, those facilities would be penalized by paying an assessment without any reimbursement.

Provider Assessment Workgroup Meeting
October 28, 2015

Thank you Madam Chairman and Secretary Hazel. My name is Jill Hanken, from the Virginia Poverty Law Center. I am here today to represent the Healthcare for All Virginians (HAV) coalition. The HAV Coalition is made up of more than 100 individual organizations including doctors, nurses, consumer groups, religious groups, and local governments from all around Virginia. We are committed to the principle that ALL Virginians should have access to affordable, quality health care.

More than 400,000 low-income, uninsured Virginians continue to struggle to get the care they need while their neighbors in Kentucky, West Virginia, and Maryland – and 27 other states plus D.C. – can get necessary care to stay healthy and productive. Virginia is now in the minority of states that have failed to close their coverage gaps.

As many of you are well aware, compared to people with insurance, the uninsured are less likely to receive preventive care or treatment for chronic diseases. When they finally seek care, they often do so through the emergency room - the most expensive place for treatment. And they often present with advanced conditions, further exacerbating the cost of care. They know the hospital can't turn them away. As a result, the patients are worse off, and the hospitals are burdened with the costs of indigent care and bad debt.

This work group offers an opportunity to explore and develop a viable plan to use provider assessments to address a number of concerns in the healthcare sector, including access to care for the uninsured. For example, a small provider assessment could be used for the state's match to draw down billions in federal funding to cover our low-income uninsured residents and in turn greatly reduce hospitals' uncompensated care costs. That's because $1 from the state would bring back at least $9 from the federal government.

The Healthcare for All Virginians coalition supports the concept of providing quality, affordable health coverage to Virginia's uninsured through a provider assessment. Beyond helping hard-working individuals and families, closing Virginia's coverage gap makes enormous financial sense for the Commonwealth. It's not too late to help Virginia's low-income, uninsured residents get the care they need. There's already been too much harm and too much suffering. We urge the work group to recommend using a provider assessment to help move Virginia forward.

Anthem.

Patrick Sturdivant
President
Anthem HealthKeepers Plus

October 23, 2015

Submitted electronically via ProviderAssessmentWorkGroup@dmas.virginia.gov

Subject: Anthem Blue Cross and Blue Shield Comments and Recommendations to the Provider Assessment Work Group

Dear Chairwoman James and Members of the Provider Assessment Work Group:

As the Provider Assessment Work Group works to complete their report to the Chairmen of the House Appropriations and Senate Finance Committees by the November 1, 2015 deadline, Anthem appreciates the opportunity to provide our comments and recommendations. We are supportive of the Commonwealth's efforts to examine ways to finance payment increases for the health safety net and/or support an expansion of the Medicaid program. However, in evaluating the financing options available, we strongly encourage the work group to consider the following points to ensure that the chosen model is both equitable and sustainable.

We recommend the work group focus their efforts on the analysis and development of a plan specific to a **hospital** provider assessment program pursuant to 2015 budget language. The General Assembly charged this work group with a statutorily prescribed list of issues to evaluate that are specifically linked to the consideration of a hospital provider assessment program.[1] There is no mention of an evaluation of other classes of providers for the purpose of this proposed assessment.

Assessing Managed Care Organizations (MCOs) will have unintended consequences, including but not limited to:

- *MCO or more specifically, Health Maintenance Organization (HMO) assessments create an unfavorable business environment in the state for MCOs.* Prior to 2005, states were allowed to implement MCO assessment programs that excluded MCOs that did not participate in the Medicaid program. With the change in federal law,[2] MCO assessment programs must now apply uniformly to all MCOs operating in a state, including those that serve only the commercial, Medicare and/or exchange populations. For these plans, the cost of the assessment is an added cost of doing business in the state for which they receive no benefit. For this reason, the number of states that employ managed care taxes to support their Medicaid programs has declined over the last decade.[3]

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[1] Title 2.2, Chapter 2; Article 6, and §2.2-200, Code of Virginia. C.1. *The Secretary of Health and Human Resources shall conduct an analysis and develop a plan with options for a hospital provider assessment program... for consideration by the General Assembly in the 2016 Session.*
[2] Deficit Reduction Act of 2005 (DRA)
[3] MacPAC. *Health Care Related Taxes in Medicaid.* August 2012.

- *An MCO assessment would hurt commercial consumers.* Commercial, Medicare and Exchange plans are unlikely to absorb the impact of an assessment. As a result, employers and enrollees will likely bear the entire burden of an MCO assessment through higher premiums. Commercial HMO consumers already see the Affordable Care Act (ACA) Health Insurer Fee (HIF) reflected in their premiums. Since this new assessment would only apply to fully insured business, this additional cost would be borne mostly by Individuals and Small employers. These are the most price sensitive customers who least can afford higher health care costs.

- *An MCO assessment would be an additional financial burden to the state.* Pursuant to federal law, MCO taxes and fees must be included in the determination of "actuarially sound" rates under the Medicaid program. As a result, a portion of an MCO assessment would effectively be paid for by the Commonwealth itself in the form of higher rates. Therefore, if there is consideration to assess the MCOs for the purpose of financing the state match for Medicaid expansion, the state would assume the cost associated with the Medicaid MCO tax; thereby, financing the assessment's intended purpose.

- *An MCO assessment would be an additional tax on Virginia health insurers that pay taxes as corporate citizens and on their health plans.* Virginia MCOs already pay hundreds of millions of dollars in taxes and fees in the Commonwealth of Virginia.

Hospital assessment programs are used in the vast majority of states to finance Medicaid payment rate increases, supplemental payments and coverage expansions. Within the constraints set by federal law, states have significant flexibility to utilize hospital assessment revenue and federal matching funds to design payments that are consistent with the state's delivery system and policy goals.

Anthem recommends hospital assessment revenues be used to raise base payment rates and to develop targeted payments to support rural providers, trauma centers, behavioral health or other areas where access improvements are needed. This would help meet the needs of the Commonwealth, including providers and Medicaid beneficiaries, and would be in alignment with a widespread use of revenues in other states' hospital assessment programs. As of 2014, 39 states employed a hospital assessment to finance a portion of their Medicaid program.

- *Federal law allows for hospital tax exemptions to protect critical providers.* Within federal regulations governing provider assessment programs,[4] states also have a great deal of flexibility to design a tax structure that ensures that key safety net providers are not adversely affected. For example, Colorado's hospital assessment exempts several types of hospitals including psychiatric hospitals, Medicare-certified long-term care hospitals, and Medicare-certified rehabilitation hospitals.[5] In addition, high-volume Medicaid hospitals, Colorado Indigent Care Program (CICP) hospitals, Critical Access Hospitals and other rural hospitals are assessed at a discounted rate.

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[4] Ibid

[5] Kaiser Commission on Medicaid and the Uninsured. Medicaid Financing Issues: Provider Taxes. May 2011.

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If the work group and later, the General Assembly determine that hospital assessment revenues be utilized to financially support Medicaid expansion, Anthem recommends the consideration of models like "Insure Tennessee." As proposed, Insure Tennessee was to be a two-year pilot, Medicaid expansion alternative program that would utilize a hospital assessment. Tennessee hospitals committed to supporting the program through a state hospital assessment when the federal match declines beginning on January 1, 2017 so there is no impact to the state budget to financially support Medicaid expansion. If the "revenues available from the assessment on hospitals fail to cover any remaining state share of expenditures in the event of a reduction in the federal match rate," the Insure Tennessee program would end.[6] Additionally, under this program, Tennessee proposed to increase the maximum of the Unreimbursed Hospital Cost Pool to offset documented unreimbursed cost. Anthem encourages the work group and the General Assembly to leverage key design components from Insure Tennessee if they choose to pursue a hospital assessment to fund expansion of the Virginia Medicaid Program.

Thank you for this opportunity to provide input on the proposed hospital assessment program for the Commonwealth of Virginia.

Sincerely,

Patrick Sturdivant
President, Virginia Medicaid

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[6] Waiver Amendment Request, TennCare Demonstration Amendment #25, INSURE TENNESSEE

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Graduate Medical Education in the Commonwealth

Provider Assessment Workgroup
October 28, 2015 Meeting

Michele L. Chesser, PhD
Senior Health Policy Analyst
Joint Commission on Health Care

Study Mandate

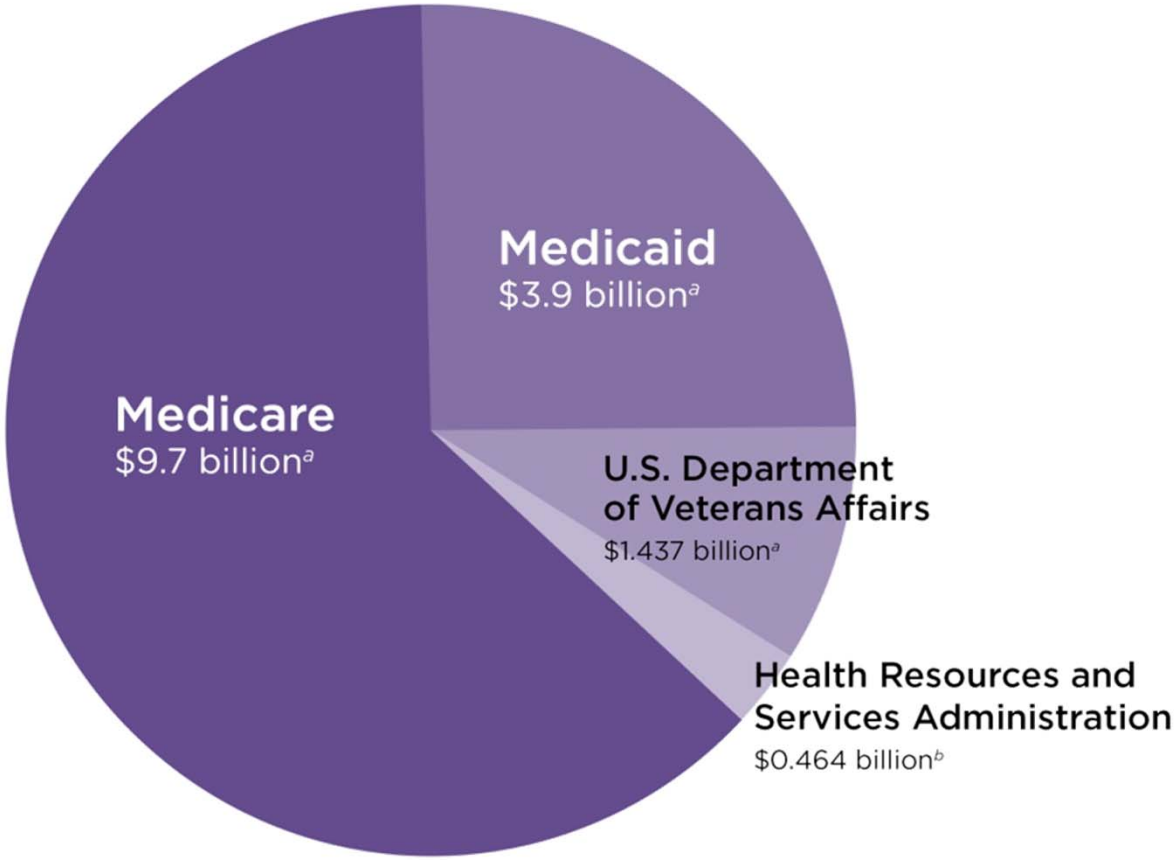
- JCHC members requested during the 2013 decision matrix meeting that JCHC staff continue to study graduate medical education in Virginia
- Senate Budget Amendment 301 #19s (2015) requested DMAS to undertake a study of federal and State funding streams for graduate medical education, and explore:
  - Ways to incentivize the expansion of clinical training opportunities and retain graduates who train in Virginia
  - Payment mechanisms that encourage primary care training programs and other specialties identified as high needs (e.g. psychiatry) as well as preferences for primary care programs that extend their training programs to community settings and underserved areas
  - Removed from conference version with the understanding by Senate Finance and House Appropriations Committees that JCHC would conduct the study

Virginia Health Workforce Development Authority (VHWDA) GME Task Force

- Approved policy option from JCHC staff study, "Update of Virginia Physician Workforce Shortage" (2013):
  - Request by letter of the JCHC Chair, that the VHWDA convene a workgroup to consider and report back to JCHC in 2015 regarding the advisability of, and if advisable, develop recommendations regarding:
    - The need for a training program for graduate medical educators. If recommended, provide program framework and funding requirements
    - A funding model for ***new*** State-supported ~~family medicine~~ residencies that could be used ***if*** the State increases appropriations for graduate medical education training. The model should include:
      - Consideration of whether funding would be used exclusively for resident training, where residencies would be located, ~~and~~ what the community or medical facility match-rates would be, *and what the impact would be of giving U.S. medical school graduates priority in filling State-supported residency programs*
  - The first meeting of the GME task force was held on May 12, 2015.
  - The second meeting was held on October 21, 2015, in which the policy options for this study were discussed.

Overview of Graduate Medical Education

GME Financing



Additional unreported funding comes from the Department of Defense, state sources, private insurers, and other private sources.

NOTE: All amounts are estimated. *a* = data from 2012; *b* = data from 2011 and 2013.
SOURCE: IOM (Institute of Medicine). 2014. *Graduate Medical Education That Meets the Nation's Health Needs*. Washington, DC: The National Academies Press. Table 3-1.

Medicare GME Funding Components

- **Direct Graduate Medical Education** Payment (DGME or DME)
  - Resident stipends and benefits
  - Faculty salaries and benefits
  - Accreditation fees
  - Institutional overhead costs (i.e. maintenance and electricity)
  - Administrative costs (personnel who work exclusively in the GME office)
- **Indirect Graduate Medical Education** Payment (IME)
  - Subsidizes hospitals for expenses associated with training resident physicians, such as higher utilization of services and longer inpatient stays
- Of the $9.7 billion spent on GME in 2012
  - DME = $2.68 billion
  - IME = $7.04 billion

Medicare DME Payment

- DME=PRA x Resident FTEs x Proportion of Medicare Patients Seen
  - PRA = Per Resident Amount
- The PRA calculation is based on hospital costs negotiated in 1983, updated for inflation
  - The DME calculation is attached to a 30-year-old payment scale that has little relevance to today's health care delivery system or current residency training programs
  - It perpetuates significant inequities in GME payments among hospitals, localities, and geographic regions

Source: IOM (Institute of Medicine). 2014. Graduate medical education that meets the nation's health needs. Washington, DC: The National Academies Press. Pg. 3-9; and AAMC podcast on GME

Medicare IME Payment

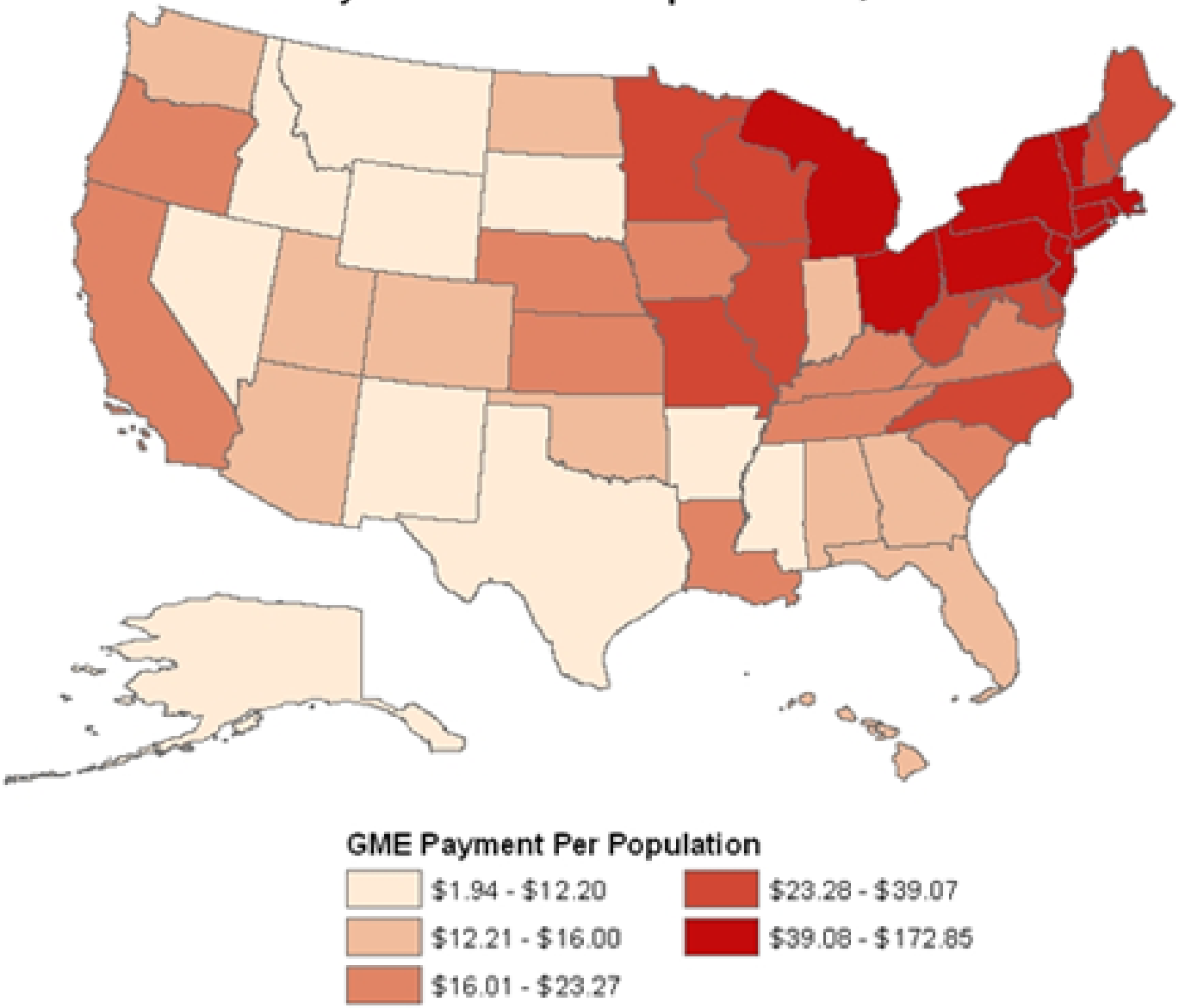
- IME is an additional payment a hospital receives on top of its normal traditional Medicare inpatient payment
- DRG Payment x [Multiplier x $((1+IRB)^{0.405} -1)$]
  - DRG = Diagnosis- related group for hospital charges
  - IRB = Intern & Resident to Bed Ratio
  - For FFY 2015, multiplier is 1.35
  - Hospitals receive about a 5.5 percent increase in the DRG payments for every approximate 10 percent increase in the IRB ratio

Medicare Resident Caps

- The Balanced Budget Act of 1997 implemented a cap on the number of resident FTEs for which a hospital could receive Medicare GME reimbursement
  - Based on the number of residents the hospital was training in 1996
  - "The geographic distribution of Medicare-supported residencies was essentially frozen in place without regard for future changes in local or regional health workforce priorities or the geography or demography of the U.S. population."
  - As a result, Medicare-supported slots are most highly concentrated in the Northeastern states, as is most of Medicare GME funding

Source: IOM (Institute of Medicine). 2014. Graduate medical education that meets the nation's health needs. Washington, DC: The National Academies Press. Pg. 3-11

State Medicare Graduate Medical Education Payment Per Population, 2010



Source: http://khn.org/news/study-points-to-imbalance-in-spending-on-doctor-training/

Medicare Resident Caps

- Nationally, two-thirds of hospitals currently train more residents than their Medicare covered cap
- In aggregate, U.S. hospitals are training 11,000 resident FTEs above the Medicare caps

Medicaid

- A state can choose to fund GME through its Medicaid program
  - Federal government provides matching funds
- The Centers for Medicare and Medicaid Services (CMS) allow states flexibility in how they utilize Medicaid funds for GME payments
- In 2012, 43 states had Medicaid GME payment programs
  - Approximately $3.9 billion in funding
  - In 2005, 48 states providing GME funding through Medicaid
    - Four states ended their program due to budget constraints
  - Aggregate Medicaid GME spending increased by $1.5 billion (63%) from 1998 to 2012
- In 2012, Medicaid GME funding exceeded $100 million in seven states (including Virginia)

Source: Hendersen, T.M. 2013. Medicaid graduate medical education payments: a 50 state survey.

Characteristics of GME in Virginia

Medical Schools and Residency Programs

Virginia Undergraduate Medical Education (UME) School Enrollment

Medical School	Annual Entering Class Enrollment	Estimated # of Graduates from Cohort
Virginia Commonwealth University	216	190-200
Virginia College of Osteopathic Medicine	188	180-186
Liberty University	160	150-158*
University of Virginia	157	145-150
Eastern Virginia Medical School	150	140-145
Virginia Tech Carillion	42	42
	Total Graduates in 2017:	**847-881**

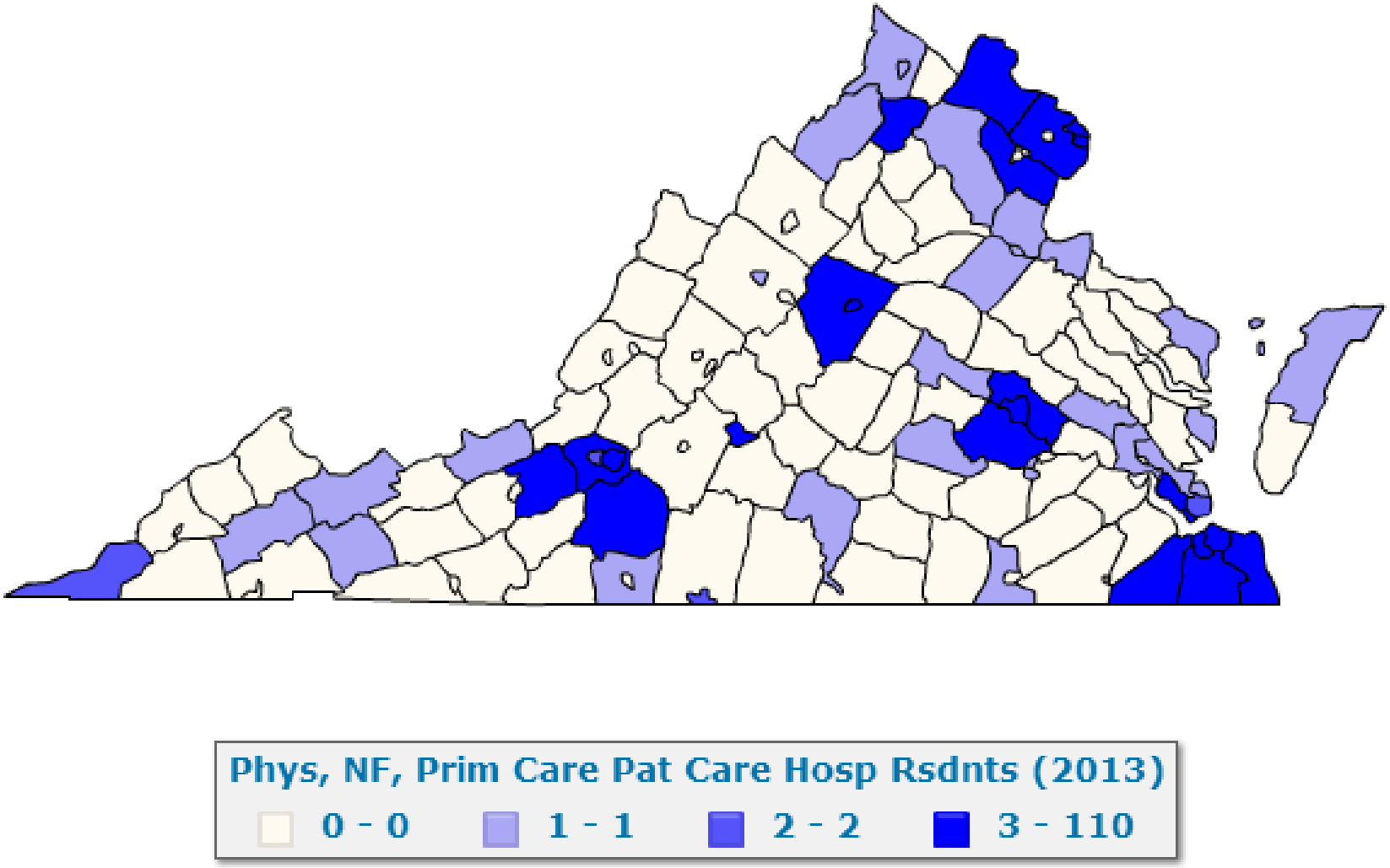
*Liberty University College of Osteopathic Medicine will graduate its first cohort in 2018

Virginia Residency Information

- 2,745 residents and fellows are currently training in Virginia
  - 1,950 are reported as positions funded by Medicare and Medicaid
  - Remainder includes privately funded positions and those funded by the military and the Department of Veterans Affairs
- 757 ACGME/AOA approved first-year residency positions
- 382 ACGME/AOA approved primary care (family medicine, internal medicine and pediatrics) first-year positions

Source: VCOM and input from MSV Deans' Forum meeting

Number of Primary Care, Non-Federal Hospital Residents (MD and DO), 2013



Source: http://ahrf.hrsa.gov/arfdashboard/ArfGeo.aspx

GME Funding

Medicare GME Reimbursement and Number of Residents by State, 2012

State	Total GME	% of U.S. Total GME	# of Residents	% of Total U.S. Residents
NY	$2,068,237,438	19.05%	16455	15.31%
PA	$941,097,699	8.67%	8171	7.60%
MI	$792,328,317	7.30%	6065	5.64%
CA	$675,698,625	6.22%	8560	7.96%
MA	$600,795,632	5.53%	4565	4.25%
OH	$582,378,875	5.36%	5934	5.52%
IL	$511,052,206	4.71%	5571	5.18%
NC	$285,858,999	2.63%	2725	2.53%
MD	$235,110,539	2.17%	2342	2.18%
VA	**$197,697,966**	**1.82%**	**2007**	**1.87%**
MN	$177,182,735	1.63%	1510	1.40%
TN	$159,776,108	1.47%	1665	1.55%
WI	$155,155,912	1.43%	1480	1.38%
GA	$146,980,463	1.35%	1664	1.55%
WA	$114,688,204	1.06%	1283	1.19%
DC	$110,042,947	1.01%	1386	1.29%
AZ	$107,762,530	0.99%	1349	1.25%
IN	$106,380,321	0.98%	1101	1.02%
LA	$105,072,775	0.97%	1689	1.57%
SC	$92,707,816	0.85%	995	0.93%
NH	$89,544,297	0.82%	638	0.59%
RI	$88,223,325	0.81%	713	0.66%
CO	$79,705,696	0.73%	1025	0.95%
OR	$79,073,147	0.73%	762	0.71%
KY	$79,026,952	0.73%	1106	1.03%
WV	$74,466,982	0.69%	708	0.66%
AL	$72,641,462	0.67%	1094	1.02%
IA	$65,732,010	0.61%	802	0.75%
OK	$58,858,182	0.54%	856	0.80%
KS	$54,185,520	0.50%	578	0.54%
NE	$46,259,700	0.43%	661	0.62%
UT	$43,809,019	0.40%	617	0.57%
AR	$36,746,034	0.34%	556	0.52%
ME	$36,323,530	0.33%	270	0.25%
DE	$33,489,149	0.31%	387	0.36%
VT	$31,634,889	0.29%	265	0.25%
NV	$28,341,345	0.26%	311	0.29%
MS	$26,218,823	0.24%	494	0.46%
HI	$23,178,087	0.21%	200	0.19%
NM	$20,248,460	0.19%	413	0.38%
PR	$15,548,469	0.14%	463	0.43%
ND	$11,218,912	0.10%	102	0.09%
SD	$9,442,093	0.09%	103	0.10%
ID	$5,670,102	0.05%	56	0.05%
AK	$2,241,598	0.02%	34	0.03%
MT	$2,222,833	0.02%	18	0.02%
WY	$1,639,971	0.02%	9	0.01%
U.S.	$10,856,102,657	100.00%	107511	100.00%

Source: CMS Hospital Cost Reports/HCRIS Files 2012

Medicaid GME Payment Amounts by the Top 15 States, 2012

STATE	Total GME Payments Under Fee-for-Service & Managed Care (Millions of Dollars)	GME Payments Under Managed Care (Millions of Dollars)	
		Implicit Payments[2]	Explicit Payments[3]
New York	**$1,815.0**	$0	$920.2
Michigan	**$163.1**	$100.0	$0
Virginia	**$142.0**	$0	$58.8
Pennsylvania	**$124.2**	$0	$0
North Carolina	**$115.7**	$0	$0
Arizona	**$113.0**	$0	Unreported
Washington	**$111.0**	$47.0	$0
South Carolina	**$110.7**	$0	$42.7
Missouri	**$110.1**	$0	$0
Georgia	**$100.9**	$0	$13.0
New Jersey	**$90.0**	$0	$0
Florida*	**$81.3**	$0	$0
District of Columbia	**$79.1**	$0	$7.3
Oklahoma	**$73.4**	$0	$57.2
Ohio	**$70.4**	Unreported	$0

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges. **NOTE: Virginia provided FY 2010 data.**

Medicare GME Reimbursement Amounts per Hospital, 2012 (Source: CMS Cost Reports)

Hospital Name	City	Hospital Beds	Medicare I & Rs FTE	Medicare DME	Medicare IME	Total Medicare
UNIVERSITY OF VIRGINIA MEDICAL CENTER	CHARLOTTESVILLE	543	673.14	$19,966,902	$50,885,134	**$70,852,036**
VCU HEALTH SYSTEM MCV HOSPITAL	RICHMOND	651	496.85	$12,935,281	$27,346,768	**$40,282,049**
CARILION MEDICAL CENTER	ROANOKE	655	159.07	$5,685,574	$10,414,074	$16,099,648
INOVA FAIRFAX HOSPITAL	FALLS CHURCH	836	161.79	$5,390,926	$10,076,766	$15,467,692
SENTARA NORFOLK GENERAL HOSPITAL	NORFOLK	471	121.38	$4,174,334	$9,906,541	$14,080,875
RIVERSIDE REGIONAL MEDICAL CENTER	NEWPORT NEWS	305	52.62	$3,002,541	$5,131,533	$8,134,074
DANVILLE REGIONAL MEDICAL CENTER	DANVILLE	215	44.03	$2,517,236	$3,723,532	$6,240,768
VIRGINIA HOSPITAL CENTER ARLINGTON	ARLINGTON	282	30.06	$1,729,508	$3,114,678	$4,844,186
ST. FRANCIS MEDICAL CENTER	MIDLOTHIAN	130	16.97	$905,360	$2,369,140	$3,274,500
LEWISGALE HOSPITAL - MONTGOMERY	BLACKSBURG	88	31.56	$1,248,059	$1,892,976	$3,141,035
CENTRA HEALTH	LYNCHBURG	439	17.07	$802,754	$1,731,518	$2,534,272
MARYVIEW HOSPITAL	PORTSMOUTH	219	16.13	$621,681	$1,517,928	$2,139,609
BON SECOURS DEPAUL MEDICAL CENTER	NORFOLK	118	11.2	$524,648	$1,097,701	$1,622,349
LONESOME PINE HOSPITAL	BIG STONE GAP	86	20.46	$729,837	$753,212	$1,483,049
SENTARA LEIGH HOSPITAL	NORFOLK	250	11.61	$436,158	$948,324	$1,384,482
NORTON COMMUNITY HOSPITAL INC.	NORTON	118	17.14	$721,857	$566,947	$1,288,804
WINCHESTER MEDICAL CENTER	WINCHESTER	389	8.03	$340,627	$788,173	$1,128,800
WARREN MEMORIAL HOSPITAL	FRONT ROYAL	46	7.54	$522,199	$599,969	$1,122,168
ST. MARYS HOSPITAL	RICHMOND	378	2.9	$276,683	$586,375	$863,058
CJW MEDICAL CENTER	RICHMOND	635	0	$256,965	$595,668	$852,633
SENTARA PRINCESSS ANNE HOSPITAL	VIRGINIA BEACH	160	3.88	$112,438	$233,404	$345,842
SENTARA VA. BEACH GENERAL HOSPITAL	VIRGINIA BEACH	257	5.01	$92,282	$209,337	$301,619
SENTARA OBICI HOSPITAL	SUFFOLK	158	1.02	$63,106	$96,731	$159,837
RIVERSIDE REHABILITATION INSTITUTE	NEWPORT NEWS	50	1	$36,254		$36,254
INOVA LOUDOUN HOSPITAL CENTER	LEESBURG	157	0.17	$4,508	$10,115	$14,623
CHILDRENS HOSPITAL OF KING'S DAUGHTERS	NORFOLK	206	93.36	$3,704		$3,704
TOTAL			**2003.99**	**$63,101,422**	**$134,596,544**	**$197,697,966**

Medicaid GME Reimbursement Amounts per Hospital, In-State, 2012

Hospital Name	City	Hospital Beds	Medicaid Utilization	Medicaid I & Rs FTE	Medicaid DME	Medicaid IME	Total Medicaid GME / IME
UNIVERSITY OF VIRGINIA MEDICAL CENTER	CHARLOTTESVILLE	543	31%	686.12	$14,673,765	$77,354,460	**$92,028,225**
VCU HEALTH SYSTEM MCV HOSPITAL	RICHMOND	651	31%	491.27	$8,140,464	$58,141,498	**$66,281,962**
CARILION MEDICAL CENTER	ROANOKE	655	26%	141.44	$1,748,310	$3,696,264	$5,444,574
INOVA FAIRFAX HOSPITAL	FALLS CHURCH	836	29%	165.32	$937,174	$3,876,338	$4,813,512
SENTARA NORFOLK GENERAL HOSPITAL	NORFOLK	471	26%	129.28	$944,458	$3,659,841	$4,604,299
RIVERSIDE REGIONAL MEDICAL CENTER	NEWPORT NEWS	305	25%	53.06	$832,206	$1,811,407	$2,643,613
CHILDRENS HOSPITAL OF KING'S DAUGHTERS	NORFOLK	206	70%	85.48	$4,174,058	$4,844,213	$9,018,271
DANVILLE REGIONAL MEDICAL CENTER	DANVILLE	215	17%	10.6	$157,123	$0	$157,123
VIRGINIA HOSPITAL CENTER ARLINGTON	ARLINGTON	282	10%	29.25	$794,381	$520,228	$1,314,609
ST. FRANCIS MEDICAL CENTER	MIDLOTHIAN	130	13%	16.56	$43,384	$442,676	$486,060
LEWISGALE HOSPITAL - MONTGOMERY	BLACKSBURG	88	9%	25.52	$217,509	$32,423	$249,932
CENTRA HEALTH	LYNCHBURG	439	18%	16.78	$245,998	$456,656	$702,654
MARYVIEW HOSPITAL	PORTSMOUTH	219	20%	14.56	$105,487	$399,913	$505,400
BON SECOURS DEPAUL MEDICAL CENTER	NORFOLK	118	11%	9.17	$88,563	$275,371	$363,934
NORTON COMMUNITY HOSPITAL INC.	NORTON	118	26%	15.97	$305,137	$183,332	$488,469
SENTARA LEIGH HOSPITAL	NORFOLK	250	14%	9.98	$55,096	$240,142	$295,238
WARREN MEMORIAL HOSPITAL	FRONT ROYAL	46	21%	8.06	$68,627	$171,079	$239,706
WINCHESTER MEDICAL CENTER	WINCHESTER	389	16%	7.56	$92,351	$80,080	$172,431
ST. MARYS HOSPITAL	RICHMOND	378	16%	7.33	$26,903	$169,002	$195,905
CJW MEDICAL CENTER	RICHMOND	635	18%	7.12	$17,467	$75,413	$92,880
SENTARA PRINCESSS ANNE HOSPITAL	VIRGINIA BEACH	160	12%	3.3	$32,784	$32,958	$65,742
SENTARA VA. BEACH GENERAL HOSPITAL	VIRGINIA BEACH	257	11%	4.88	$24,357	$67,846	$92,203
SENTARA OBICI HOSPITAL	SUFFOLK	158	17%	1	$27,811	$57,771	$85,582
RIVERSIDE REHABILITATION INSTITUTE	NEWPORT NEWS	50	13%	1	$4,531	$0	$4,531
INOVA LOUDOUN HOSPITAL CENTER	LEESBURG	157	14%	0.11	$210	$2,062	$2,272
SENTARA CAREPLEX HOSPITAL	HAMPTON	218		0	$0	$940	$940
TOTAL				**1940.72**	**$33,758,154**	**$156,591,913**	**$190,350,067**

NOTE: Medicaid also provides $2,516,132 of GME reimbursement for the training of residents in Allied Health. Source: DMAS

Medicaid GME Reimbursement Amounts per Hospital, Out-of-State, 2012

Hospital Name	City	State	Hospital Beds	Medicaid Utilization	Resident FTEs	Medicaid DME	Medicaid GME (Allied Health)	Medicaid IME	Total Medicaid
JOHNSON CITY MEDICAL CENTER	JOHNSON CITY	TN	511	20%	128.7	$106,451	$11,391	$565,683	$683,525
NORTH CAROLINA BAPTIST HOSPITAL	WINSTON-SALEM	NC	776	21%	614	$420,145	$26,690	$0	$446,835
BRISTOL REGIONAL MEDICAL CENTER	BRISTOL	TN	255	11%	36.73	$105,546	$4,567	$237,400	$347,513
HOLSTON VALLEY HOSP & MED CTR	KINGSPORT	TN	435	17%	45.5	$57,452	$3,420	$285,600	$346,472
DUKE UNIVERSITY HOSPITAL	DURHAM	NC	801	27%	601.17	$341,109	$2,343	$0	$343,452
GEORGETOWN UNIVERSITY HOSPITAL	WASHINGTON	DC	381	15%	280.9	$154,352	$4,460	$0	$158,812
CHILDRENS HOSPITAL NMC	WASHINGTON	DC				$126,569	$0	$0	$126,569
GEORGE WASHINGTON UNIV HOSPITAL	WASHINGTON	DC	315	25%	250.91	$68,571	$0	$30,652	$99,223
INDIAN PATH MEDICAL CENTER	KINGSPORT	TN	147	17%	2.03	$66,396	$0	$7,934	$74,330
WASHINGTON HOSPITAL CENTER	WASHINGTON	DC	715	12%	304.95	$35,926	$2,820	$0	$38,746
NATIONAL REHABILITATION HOSPITAL	WASHINGTON	DC	137			$1,749	$0	$0	$1,749
TOTAL					**2264.9**	**$1,484,266**	**$55,691**	**$1,127,269**	**$2,667,226**

Source: DMAS

Total Medicare and Medicaid GME Reimbursements, Virginia, 2012

Payment Type	Amount
Medicaid In-State DME + IME	$190,350,067
Medicaid In-State Allied Health GME	$ 2,516,132
Medicaid Out-of-State DME+IME+ Allied Health GME	$ 2,667,226
Total Medicaid	$195,533,425
	($ 97,766,712 in State GFs)
Total Medicare	$197,697,966
Total GME Payments	$393,231,391

Sources: CMS Cost Reports and DMAS

State General Fund Appropriations for GME

- The Virginia State Budget (FY 2015-2016) includes the following GF appropriations for the support of family medicine residency programs at Virginia Commonwealth University, University of Virginia, and Eastern Virginia Medical School
  - VCU: $4,336,607
  - UVA: $1,393,959
  - EVMS: $722,146
- Residency funding has remained the same or decreased over time
  - As a result, funding has not kept pace with the increasing costs of residency programs
  - There is concern that the number of family medicine residencies will have to be reduced in 2016
  - Currently the health systems sponsoring the residency programs are subsidizing the State funding
    - This model is considered to be unsustainable

Source: Interviews with representatives of VCU, UVA, and EVMS

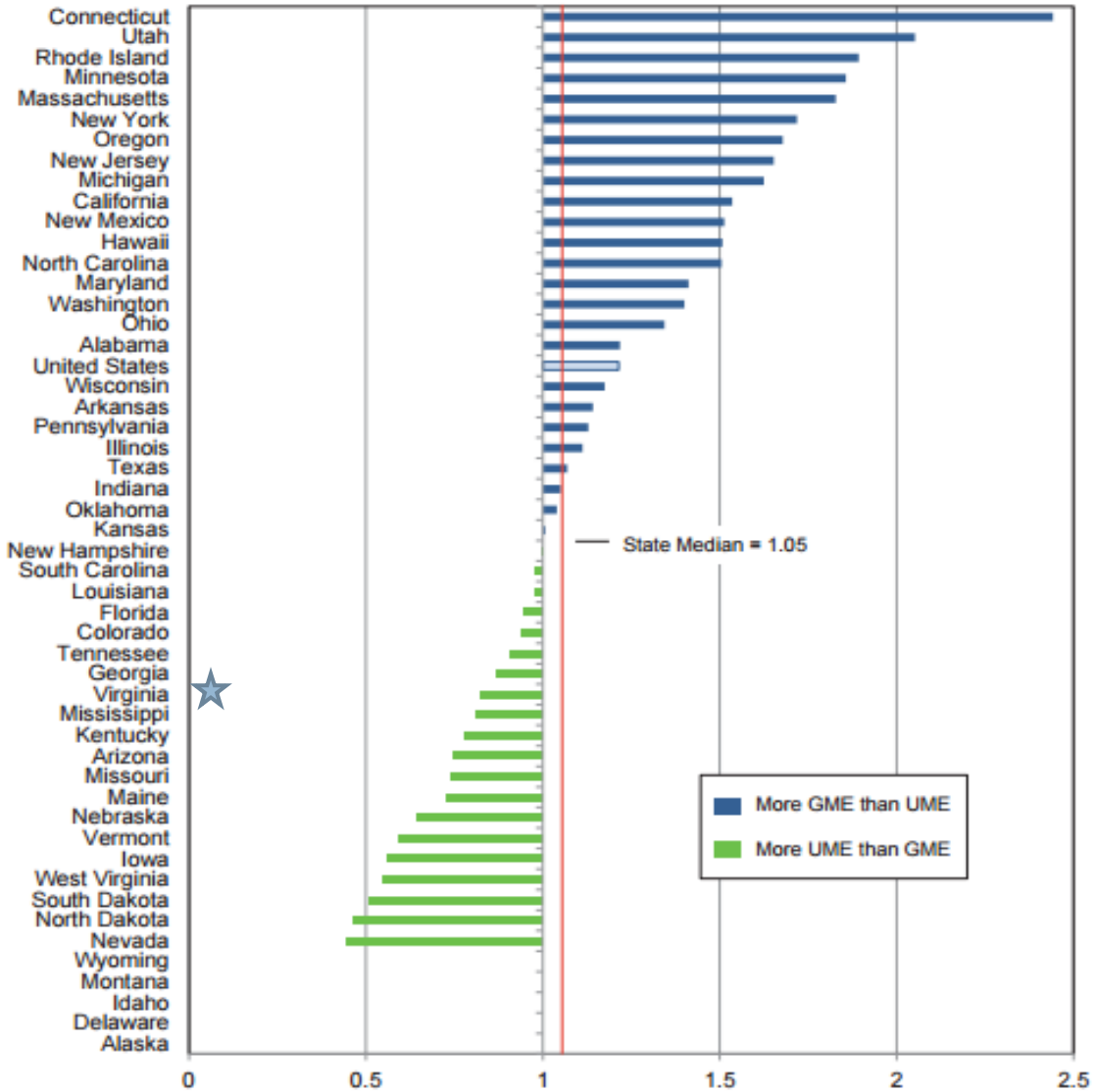
Availability of Residency Positions

Change in the Number of Medical Schools, Medical School Enrollment, and Applicants to GME Programs, 2002 - 2012

	2002	2012	10 Year Change	
			Number	**Percent**
NUMBER OF MEDICAL COLLEGES	145	175	30	20.7%
Allopathic	125	141	16	12.8%
Osteopathic	20	34	14	70.0%
STUDENTS ENROLLED IN U.S. MEDICAL COLLEGES	80,180	102,498	22,318	27.8%
Allopathic	68,748	80,757	12,009	17.5%
Osteopathic	11,432	21,741	10,309	90.2%
U.S. MEDICAL SCHOOL GRADUATE APPLICANTS TO GRADUATE MEDICAL EDUCATION (GME) PROGRAMS	16,874	20,248	3,374	20.0%
INTERNATIONAL MEDICAL GRADUATE (IMG) APPLICANTS TO GME PROGRAMS	6,585	11,107	4,522	68.7%
U.S. citizen IMG's	2,029	4,279	2,250	110.9%
Non-U.S. citizen IMG applicants	4,556	6,828	2,272	49.9%
TOTAL POTENTIAL APPLICANT POOL FOR GME POSITIONS (U.S. PLUS IMG'S)	23,459	31,335	7,896	33.7%

Source: IOM (Institute of Medicine). 2014. Graduate medical education that meets the nation's health needs. Washington, DC: The National Academies Press.

Ratio of Residents and Fellows (GME) to Allopathic and Osteopathic Students (UME), Academic Year 2011-2012



Source: www.aamc.org/data/workforce/359282/2013physician.html

Retention of Residents in Virginia

Virginia Physician Retention, 2012

	Virginia	Virginia Rank	State Median
% of physicians retained in Virginia from undergraduate medical education (UME)	33.7%	31	38.7%
% of physicians retained in Virginia from UME (public)	33.9%	35	44.9%
% of physicians retained in Virginia from GME	38.8%	40	44.9%
% of physicians retained in Virginia from UME and GME	64.3%	29	68.1%

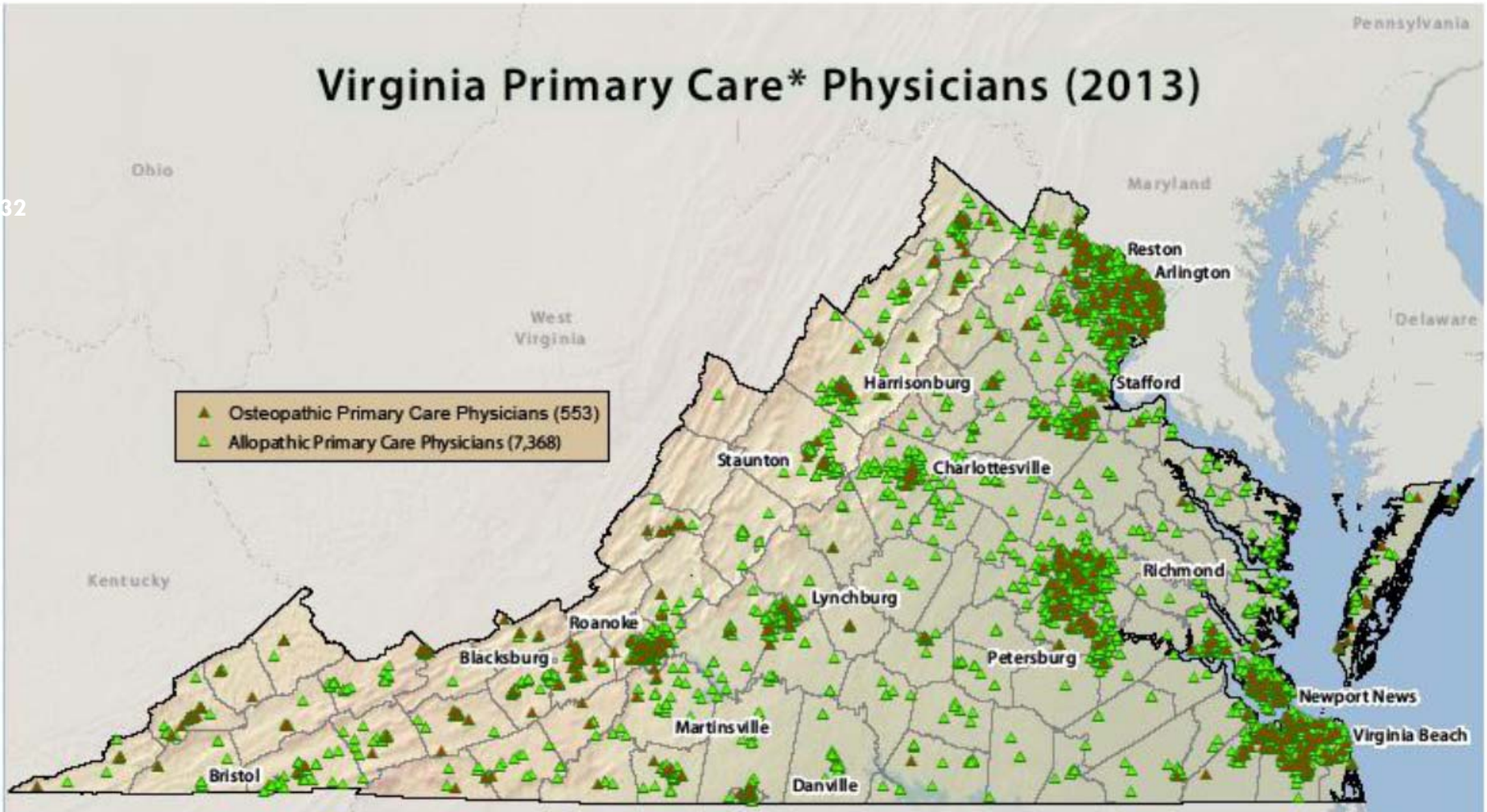
State Rank: How a state ranks compared to the other 49. Rank 1 goes to the state with the highest value for the particular category.

State Median: The value directly in the middle of the 50 states, so 25 are above the median and 25 are below.

Source: 2013 State Physician Workforce Data Book

Physicians in Rural and/or Underserved Areas of Virginia

Virginia Primary Care* Physicians (2013)



	Total	Family Medicine	General Practice	Internal Medicine	Obstetrics and Gynecology	Pediatrics	Total Primary Care	%	PC in Rural	%	PC in MUA	%	PC in PC-HPSA	%
Osteopathic Physicians	1,201	296	38	123	46	50	553	46%	118	21%	69	12%	27	5%
Allopathic Physicians	21,176	2,506	335	1,051	2,087	1,389	7,368	35%	904	12%	644	9%	210	3%
Totals	22,377	2,802	373	1,174	2,133	1,439	7,921	35%	1,022	13%	713	9%	237	3%
% Change from 2008	4%	16%	6%	41%	117%	14%	13%		3%		56%		67%	

Data Sources: NCAHD's Enhanced State Licensure Data (2013); Rural based on OMB Metro/Non-Metro definition (06/2010); PC-HPSA and MUA from HHS/HRSA (08/2013)

*Primary Care Physicians include the following specialties: Family Medicine, General Practice, Internal Medicine, Obstetrics & Gynecology, and Pediatrics

NCAHD

Map created by the National Center for the Analysis of Healthcare Data August, 2013

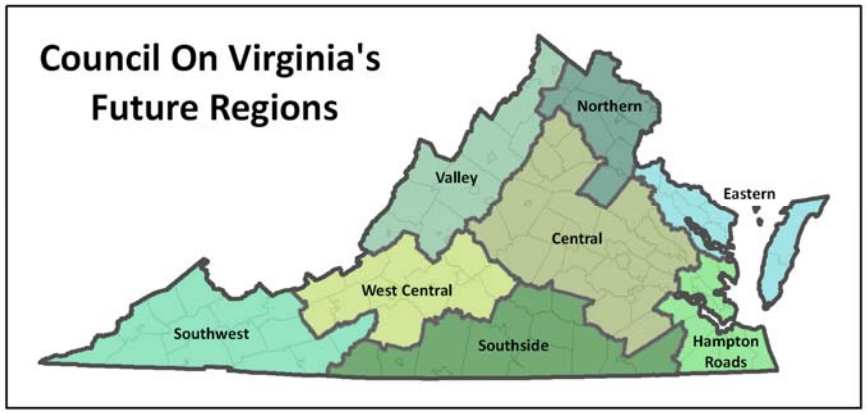
Physicians in Rural and/or Underserved Areas of Virginia

- 18 percent of Virginia's physicians grew up in a rural area, 15 percent of these professionals currently work in non-metropolitan areas of the state
- Overall, eight percent of Virginia's physicians work in non-metropolitan areas of the state
- According to the Association of American Medical Colleges, **18.2 percent of Virginia's physicians** practice in a geographical Medical Underserved Area (MUA)
  - Maryland: 32.4%
  - Kentucky: 33.6%
  - North Carolina: 35.3%
  - West Virginia: 40.7%
  - Tennessee: 26.7%
  - South Carolina: 34.3%

Sources: Virginia Department of Health Profession, Healthcare Workforce Data Center, "Virginia's Physician Workforce, 2014." GME Track as of August 21, 2014 and AMA Physician Masterfile as of December 31, 2013 via AAMC website.

Regional Distribution of Virginia's Physicians, 2014

Regional Distribution of Work Locations				
COVF Region	Primary Location		Secondary Location	
	#	%	#	%
Central	5,320	24%	1,151	19%
Eastern	306	1%	110	2%
Hampton Roads	4,354	20%	1,054	17%
Northern	6,659	30%	1,850	31%
Southside	543	2%	163	3%
Southwest	719	3%	208	3%
Valley	1,167	5%	257	4%
West Central	2,422	11%	594	10%
Virginia Border State/DC	306	1%	268	4%
Other US State	315	1%	382	6%
Outside of the US	6	0%	21	0%
Total	22,117	100%	6,058	100%
Item Missing	1,898		126	



% of State Population:

6.3%

7.2%

9.8%

Sources: Virginia Department of Health Profession, Healthcare Workforce Data Center, "Virginia's Physician Workforce, 2014."

Considerations for Improving Graduate Medical Education in Virginia

Address the Needs of Rural and Underserved Areas in Virginia

Start-Up Funding for (1) New Residency Programs in Naïve Hospitals and/or (2) Residency Programs Based on the Teaching Health Center GME Program Model

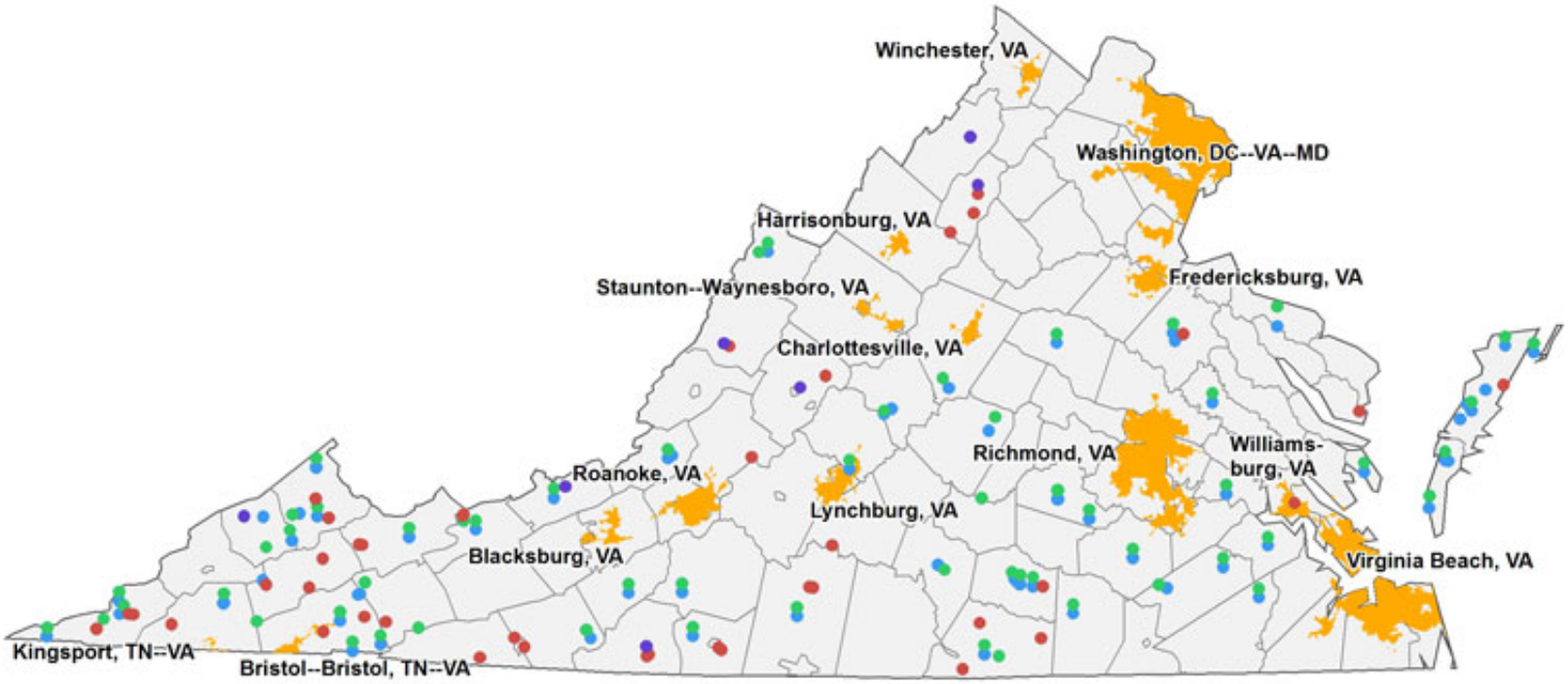
- Hospitals that have not trained residents (referred to as naïve hospitals) can start new residency programs and have up to 5 years to establish their residency cap for Medicare and Medicaid GME funding
  - While these programs are sustainable like other residency programs once they receive Medicare and Medicaid GME reimbursements, most naïve hospitals lack the initial funding required to develop a residency program
    - Initial funding is needed to purchase teaching equipment, faculty development, etc.
  - Providing seed money for naïve hospitals would increase the number of residency positions in the State and, in most cases, increase the number of residency programs in rural or underserved areas
    - Individuals who complete their residency in rural or underserved areas are more likely to practice in these areas

Address the Needs of Rural and Underserved Areas in Virginia

- Teaching Health Center GME Program
  - $230 million, 5-year initiative created by the Affordable Care Act to increase the number of primary care residents and dentists trained in community-based settings
  - Funding pays for direct and indirect medical education expenses for training residents in new or expanding community-based primary care residency programs.
    - Clinical training sites include federally qualified health centers (FQHCs) and FQHC look-a-likes, community mental health centers and rural health clinics
  - During 2015 academic year, 60 Teaching Health Center Graduate Medical Education programs in 24 states supported more than 550 residents
  - While the federal program is no longer accepting applications, states can develop similar programs to encourage primary care residencies in FQHCs and other clinics
    - Provides residency training in a community setting needed to prepare future primary care physicians
    - Training in a community clinic increases the likelihood of practicing in that setting and providing care for underserved members of the community
    - Second and third year residents enable the community clinic to provide care to more patients

Source: http://bhpr.hrsa.gov/grants/teachinghealthcenters/

Selected Rural Health Care Facilities in Virginia



Miles
0 25 50 100

- Critical Access Hospital
- Rural Health Clinic
- Federally Qualified Health Center in a Non-Urbanized Area
- FQHC Service Delivery Site in a Non-Urbanized Area
- Urbanized Area

Sources: U.S. Census Bureau, 2012 TIGER/Line.
Centers for Medicare and Medicaid Services;
U.S. Department of Health and Human Services;
May 2015.

RAC
Rural Assistance Center

Address the Needs of Rural and Underserved Areas in Virginia

Sole Community Hospital (SCH) Residency Fund

- The Centers for Medicare and Medicaid Services classify a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals and its patients are unlikely to travel outside of the hospital's service area for treatment
- SCHs receive additional Medicare payments and, therefore, are not eligible to receive Medicare IME payments

Address the Needs of Rural and Underserved Areas in Virginia

Establishing a Sole Community Hospital Residency Fund would:

- Provide additional payments to SCHs that establish new primary care medical residency programs
- Payment would be equal to the difference between an established per resident amount (PRA) and GME payments received by the SCH from Medicare and Medicaid calculated utilizing the formula for Type 2 hospitals
- Payment would be highest in the first year and decrease in years two and three to reflect decreasing costs per resident as more are added to the program

Address the Needs of Rural and Underserved Areas in Virginia

Sole Community Hospital Residency Fund

- The program would tie future payments to retention of residents in medically underserved areas in the Commonwealth
- Provide incentives, through loan repayment, for residents to practice in medically underserved areas

Address the Needs of Rural and Underserved Areas in Virginia

Sole Community Hospital Residency Fund

The following are Virginia's sole community hospitals

(Note: Not all can support graduate medical education for financial or capacity reasons)

- Alleghany Regional
- Augusta Health Care
- Buchanan General
- Community Memorial
- Halifax Regional
- Rappahannock General
- Rockingham Memorial
- Shore Memorial
- South Hampton
- Southside Community
- Tidewater Memorial
- Twin County Regional
- Wythe County

Update Virginia's Medicaid GME Payment System

- The per resident amount (PRA) used to determine reimbursements to teaching hospitals/GME sponsoring institutions is based on 1998 fee-for-service costs
  - Inflated annually except when inflation has been frozen
    - Payments have not kept up with actual costs per resident
- On average, Medicaid GME payments cover 40% of Medicaid GME costs based on FY 2012 data inflated to FY 2016
- Since payments have not been rebased since 1998, the percent of cost varies from 10 percent to over 100 percent of a hospital's cost

Source: DMAS presentation to the Provider Assessment Work Group. September 30, 2015 and communications with Bill Lessard

Update Virginia's Medicaid GME Payment System

- Private hospitals making the largest investment in medical education have a lower percent of their costs reimbursed
- Virginia's Medicaid IME Reimbursement Formula is based on
  - Operating payments at 70% to 80% of cost times
  - An IME factor using the ratio of residents to beds
    - The current Medicare formula increases payments 5.5 percent for each 10 percent increase in the resident to bed ratio
    - The DMAS formula is about 80% of the Medicare formula
- DMAS could amend the State plan to rebase the costs used to establish the per resident amount used for DME payments
  - DMAS would rebase every four years

Source: DMAS presentation to the Provider Assessment Work Group. September 30, 2015 and communications with Bill Lessard

Increase Medicaid GME Funding for Needed Specialties

- Enhance DME and IME payments to GME programs in Virginia for the specialties identified with shortages (primary care, general surgery, psychiatry, geriatrics, and emergency medicine)
  - A 2009 approved JCHC policy option recommended DMAS review the plan
  - In 2011, DMAS completed a study to determine methodology and cost estimates
    - Since both public hospitals (UVA and VCU) were already at the upper payment limit, the analysis was limited to private hospitals
    - For private, in-state hospitals: An additional $1.77 million ($884,405 in GF) would be required for a 10 percent increase in funding for all specialties identified with shortages

Increase Medicaid GME Funding for Needed Specialties

- The Virginia Hospital and Healthcare Association's 2013 Healthcare Workforce Strategic Planning Task Force made the following recommendation:
  - Request that DMAS amend the State plan to establish an additional Medicaid health professional training supplemental payment. Funds would be based on an average per resident amount of $140,000
    - Criteria developed by DMAS would set aside half of the available funds to support expansion of primary care training programs and the remainder for other needed specialties (e.g. psychiatry)
    - Preference for primary care programs would be given to programs that extend their training to community settings, especially in rural or underserved areas

Virginia State Loan Repayment Program (SLRP) Funding

- Provides a non-taxed incentive to qualified medical, dental, behavioral health, and pharmaceutical (pharmacists) professionals in return for a minimum of two years of service at an eligible practice site in one of the federally designated Health Professional Shortage Areas (HPSAs)
- SLRP requires a dollar for dollar match from the community or practice site
- The maximum award for a four-year commitment is $140,000 and must be used to decrease debt on a qualifying educational loan
- Total SLRP funds in 2015: $317,200
  - Funded 11 recipients

Source: https://www.vdh.virginia.gov/OMHHE/primarycare/incentives/loanrepayment/

Establish Workforce and GME Data Collection Program

- Data is needed to determine whether the State's GME system is meeting the needs of the Commonwealth at the State, regional and individual level
- The collection of financial, programmatic and outcomes data for residency programs in the State will enable targeted and informed policy recommendations
- The program also could evaluate State best practices for maximizing retention of health professional school program graduates in post-graduate clinical training programs and practice settings, and establish and track improvement targets

Establish a Governance Structure for Virginia's GME System

- The federal government and most states do not have an organizational structure to provide oversight of the GME system or GME funding
- A GME governing body could:
  - Guide workforce and GME data collection
  - Provide policy recommendations and oversee policy implementation
  - Assure that the GME system is meeting the needs of the State and each of its regions
- Equal regional representation could be achieved through the creation of regional organizations that would oversee initiatives in their region
  - Southwest Graduate Medical Education Consortium (GMEC)

Policy Options

- **Option 1**: Take no action
- **Option 2**: Request by letter of the JCHC Chair that DMAS determine a plan, including budget estimates, to rebase the costs used to establish the per resident amount for DME payments and report to JCHC by September 2016.
  - Include estimates for rebasing up to 100% of Medicaid's portion of a hospital's GME cost.

Policy Options

- **Option 3**: Introduce budget amendment (language and funding) for DMAS to amend the State plan to establish an additional Medicaid health professional training supplemental payment. Funds would be based on an average per resident amount of $140,000
  - Criteria developed by DMAS would set aside half of the available funds to support expansion of primary care training programs and the remainder for other needed specialties (e.g. psychiatry).
  - Preference for primary care programs would be given to programs that extend their training to community settings, especially in rural or underserved areas.

Policy Options

- **Option 4**: Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, contact hospitals that have never had residency programs to determine which ones may be interested in developing such programs and what support, including seed money, might be needed to develop successful programs.

Policy Options

- **Option 5**: Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the Virginia Community Healthcare Association and the stakeholder Graduate Medical Education Advisory Group, assess whether it is prudent to develop residency programs based on the Teaching Health Center GME Program Model in Virginia and, if so, what would be needed to develop successful programs, with a report to the Commission by September 2016.
- **Option 6**: Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, assess whether it is prudent to develop a Virginia Sole Community Hospital Residency Fund and, if so, what would be needed to develop successful programs, with a report to the Commission by September 2016.

Policy Options

- **Option 7**: Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, assess the effectiveness of the State Loan Repayment Program and the potential benefits of expansion of the program, with a report to the Commission by September 2016.
- **Option 8**: Request by letter of the JCHC Chair that the Virginia Health Workforce Development Authority, working with the stakeholder Graduate Medical Education Advisory Group, develop a plan for a GME governing body in Virginia, whose responsibilities would include:
  - Guide workforce and GME data collection
  - Provide policy recommendations and oversee policy implementation
  - Assure that the GME system is meeting the needs of the State and each of its regions

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