OGME Development Initiative
Consultant Training Webinar
June 21, 2011

Consultants

Q: What criteria are used in recommending consultants?

A. The Initiative makes the arrangements for all consultant conference calls and site visits. In assigning consultants to work with a hospital, every effort is made to match the hospital with individuals who have the knowledge and expertise needed to address its interests and circumstances. For example, if a hospital is interested in dual accreditation, a least one of the consultants will have experience with dual accreditation. Now that the specialty colleges have appointed representatives to the Initiative, consultants knowledgeable about specialty standards and inspection criteria are available to work with hospitals interested in programs in their particular specialty. For example, a hospital interested in starting an internal medicine program can be assigned to work with a consultant with knowledge and expertise in starting IM programs. Because each hospital will work with at least 2 Initiative consultants a mix of skills and experience will be available to help it navigate the development process.

Role of OPTIs and the OGME Development Initiative

Q: Some OPTIs work with nonteaching hospitals on starting new residencies and charge for their services. When do the OPTIs play this role and when does the AOA provide these services?

A: Increasing the number of osteopathic training positions is a challenge facing the entire profession. The Initiative works collaboratively with the OPTIs to assist hospitals interested in starting new OGME programs. It also works with COMs, state associations, specialty colleges and others who bring "leads" to prospective teaching hospitals to the Initiative's attention. Many hospitals that contact the Initiative are just beginning to explore GME. They need basic information on the benefits of starting a program and the resources needed to develop one. Many are not aware of OPTIs or the critical role they play in osteopathic medical education. Others may be aware of OPTIs but, as yet, have not selected an OPTI partner. For these hospitals the Initiative serves as the point of entry and stresses the value of OPTI affiliation early in the process.

If the hospital already has selected an OPTI every effort will be made to coordinate activities, including conference calls and site visits. Conversely, OPTIs and COMs often request Initiative assistance as they work with potential teaching hospitals in their areas. Collaboration between the Initiative and the OPTIs helps the profession provide consistent messages and support for a hospital's efforts at both the local and national level.

GME Funding

Q: Significant dollars must be invested to start new programs. It takes approximately 4 years for the Centers for Medicare and Medicaid Services (CMS) to determine what payment will be. Is there a "rule of thumb" hospitals can count on for interim reimbursement?

A: Medicare GME payment is very hospital specific. Both the direct graduate medical education (DGME) and indirect medical education (IME) payment formulas depend on hospital-specific data such as the hospital's percentage of Medicare patients, gross revenues and number of available beds. Although rough calculations can be made using these formulas and the anticipated number of residents, once a hospital has decided to start a program hospital representatives should meet with the hospital's Medicare contractor to discuss plans for the new program. The contractor will help the hospital understand documentation and reporting requirements.

To help hospitals get a more detailed idea of start-up costs and payment, the Initiative maintains a list of commercial consultants skilled in creating multi-year financial pro formas. These individuals have worked with existing OGME programs and participated in AOA, AACOM or AODME conferences, presenting to their members. Contact information is available from the Initiative upon request. Fees for the services of these individuals are subject to agreement between the hospital and commercial consultant. The Initiative receives no financial benefit from these agreements and is not a guarantor of their services.

Q: What is the process for getting new GME "slots" approved and reimbursed by Medicare and Medicaid?

A: As a prerequisite to payment, Medicare requires a hospital to have an "approved" medical residency program. Medicare regulations define an approved program as a program approved by one of four specified accrediting organizations, including the AOA. The hospital's Medicare contractor can point the hospital to requirements for documenting resident rotations and reflecting them on the Medicare cost report.

Q: My understanding is that it takes about 18 months or more for hospitals to start to recoup some of their costs of starting a new program. Is that still correct?

A: In the ordinary course, Medicare starts paying a hospital when training begins and residents are listed on the hospital's cost report. Although an 18-month timeline is frequently cited, new teaching hospitals should work with their Medicare contractors to determine whether accepting Medicare periodic interim payments (PIP) would facilitate earlier payment.

Q: How important is it to review a hospital's cost report and other financial indicators before moving forward with residency program development?

A:	As stated above, Medicare GME payment is very hospital-specific. For example, DGME payment is the product of the number of full time equivalent (FTE) residents that may be counted under Medicare payment rules, the hospital's per resident amount (PRA) and its Medicare utilization rate. The Medicare utilization rate, generally referred to as the "Medicare share," is particularly important. Defined in regulations as the ratio of Medicare patient days to all patient days, a Medicare share that is sufficiently robust is necessary to support a high quality, financially successful program.

By the same token, IME payment is the product of the IME adjustment factor for the current year (established by statute), the hospital's DRG payments and its teaching intensity, defined as the ratio of residents to "available beds" as defined in Medicare regulations. Given the nature and specificity of these formulas, accurate data are critical to determining whether a new teaching program will be financially viable and, if not, whether there are ways to improve its prospects. Hospitals are asked to provide key data to the Initiative early on to facilitate the consultation process.

A:	Does the Initiative have a list of hospital CFOs and reimbursement specialists who are willing to help educate hospitals CEOs considering GME programs on how to set up and receive reimbursements for residency programs?

Q:	Many of the hospitals that seek assistance from the Initiative are at the early stages of considering an OGME program. Consequently, much of the Initiative's efforts have focused on educating the hospitals on such topics as strategic decision-making, the benefits of operating a program and the resources and steps that are required. Because the Initiative works collaboratively with the OPTIs, the balance of responsibility for assisting the hospital generally shifts to the local (OPTI) level as the hospital moves forward in the development process. Moreover, hospital CFOs work closely with the Medicare contractors on a variety of cost finding and reporting issues. Hospitals planning to establish new OGME programs are advised to meet with their Medicare contractors to lay out their plans for OGME and assure that they understand documentation requirements.

Number of Residents

Q:	When developing residencies in new teaching hospitals is there a good rule of thumb for estimating the number of resident positions the hospital can support?

A:	The number of residents a hospital can support will depend on the hospital's size, resources, faculty and the scope, variety and volume of experiences it can provide to its residents. Both the AOA Basic Standards and the standards of all osteopathic specialty colleges are available on the OGME Development Initiative Webpage, http://www.osteopathic.org/ogmedevelopment.

Initiative consultants knowledgeable about the specialty college standards and inspection criteria are available to assist hospitals interested in starting programs in their specialties.

Starting Multiple Residencies

Q: How does a new hospital determine the best approach to the development of multiple residency programs? Is it important to make application for multiple programs at the time of the initial request?

A: For new teaching hospitals the Medicare "cap" will be established based on the highest number of residents in any program year in the program's fifth year multiplied by the "initial residency period" - the number of years it takes residents to become Board eligible in their particular specialty. For example, a new teaching hospital starts 3 specialty programs: 8 residents in family medicine, 6 residents in general surgery and 6 more in emergency medicine. If the hospital has residents training in all these positions during any program year as of the third year of its program, with no outside rotations, its cap is 8 x 3 years for FM, 6 x 5 years for surgery and 6 x 4 years for EM, for a total of 78 positions. Thereafter, so long as it has approval for the requisite number of residents, the hospital can add new specialty programs or additional residents. It will only receive Medicare payment, however, up to the number of residents in its cap. (The regulations provide an exception for new teaching hospitals classified as "rural" for Medicare cost reporting purposes. These hospitals can add new specialty programs but cannot add residents to existing programs.)

Although the hospital has 5 years to build its cap it need not start all programs in the first year. The multiplier effect of the initial residency period will assure that there are sufficient cap slots for the residents to finish as new residents enter training. Within the initial 5-year period, however, the hospital must secure approval for training in the desired specialties, appoint faculty, begin training residents and fill as many slots as possible to establish its cap. The hospital cannot count residents for the time they train in other hospitals.

OPTI Sponsorship of OGME Programs

Q: How will the Initiative present the new requirement for each OGME program to have an OPTI as its academic sponsor?

A: In its final report, the Education Policy and Procedure Review Committee (EPPR III) recommended a change to the AOA Basic Standards to recognize OPTIs as the academic sponsors of all AOA-approved OGME programs. Consistent with that recommendation, the AOA Board of Trustees approved Resolution 45 at its July 2011 meeting.

In accordance with Resolution 45, the AOA Basic Standards have been amended to require that all AOA-approved OGME programs must function under the authority of an AOA-accredited sponsoring OPTI no later than July 1, 2012. An OPTI seeking to be the academic sponsor of an AOA-approved OGME program at a "base institution" must have been provisionally accredited for at least 6 months or longer preceding the date of approval of the training program(s). Operational and financial responsibility for a training program remains in its base institution. Base institutions may include hospitals, federally qualified health centers, teaching health centers, freestanding accredited ambulatory surgery centers, and colleges of osteopathic medicine.

Under the revised Basic Standards academic sponsors are responsible for monitoring OGME programs in their partner base institutions and maintaining OPTI affiliation/sponsor agreements with those institutions. Academic sponsors are accountable for the base institutions' compliance with AOA policies on contracts, the AOA Match program, quality performance, trainee evaluations, participation in on-site program reviews, and for corrective action plans, internal reviews and core competency compliance. Consultants should counsel prospective teaching hospitals about OPTIs and the critical role they play in OGME, including academic sponsorship. Hospitals should be encouraged to select an OPTI early in the process as academic sponsorship will be a central part of the program application process.

Physician Workforce Shortages & Shortage of Residency Positions

Q: A recent report from the Association of American Medical Colleges stated that enrollments in allopathic medical schools are expected to reach 21,041 by 2015, a 27.6% increase over 2002. Where is the AOA going to identify institutions interested in OGME and starting dual accredited programs when the flow of USMGs is starting to turn into a flood?

A: With the number of medical students rapidly increasing, the AOA is pursuing a number of strategies to increase the number of postdoctoral training positions for osteopathic graduates. Besides implementing the OGME Development Initiative, the AOA supports legislation to modify Medicare caps on existing programs. It also works with Congress and the Centers for Medicare and Medicaid Services to assure that osteopathic programs are treated equitably under existing laws, regulations and agency policies.