


GRADUATE MEDICAL EDUCATION IN THE COMMONWEALTH
JOINT COMMISSION ON HEALTH CARE
OCTOBER 7, 2015 Meeting

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Study Mandate



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- 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

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- 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 and the second meeting is scheduled for October 21, 2015

Presentation Outline

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- Overview of Graduate Medical Education (GME)
 - Sources of GME Funding
 - Challenges of the Current GME System in the U.S.
- Characteristics of GME in Virginia
 - Medical Schools and Residency Programs
 - Funding
 - Availability of Residency Positions
 - Retention of Residents
 - The Healthcare Needs of Rural and Underserved Areas
- Considerations for Improving GME in Virginia
- Policy Options

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Overview of Graduate Medical Education

Graduate Medical Education

- Graduate medical education (GME) refers to the period of education in a medical specialty/subspecialty, following the completion of a recognized undergraduate medical education, which prepares physicians for the independent practice of medicine in that specialty/subspecialty
 - ▣ Also referred to as residency education
- The two residency program accreditation bodies, the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA), will be merging to a single accreditation system for graduate medical education programs in the U.S.
 - ▣ AOA-accredited training programs will transition to ACGME accreditation by June 30, 2020

Source: acgme.org. Glossary of Terms

Primary Sources of GME Funding

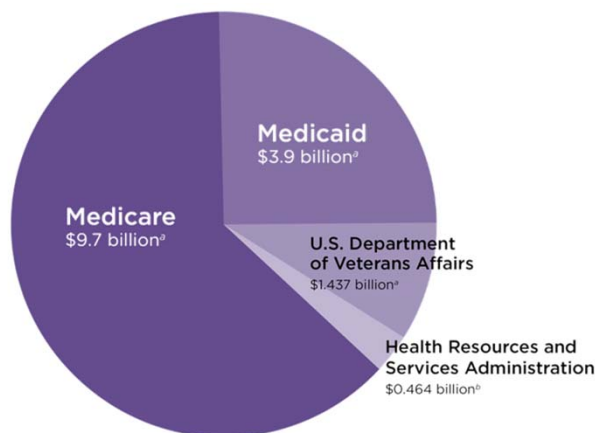
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- Medicare
- Medicaid
- Veterans Administration
- Health Resources and Services Administration (HRSA)
 - ▣ Children's Hospitals GME
 - ▣ Teaching Health Centers GME
 - ▣ National Health Service Corp (NHSC) Loan Repayments
 - ▣ Title VII Primary Care Programs
- Department of Defense
- Self-Funding by Resident Training Institutions



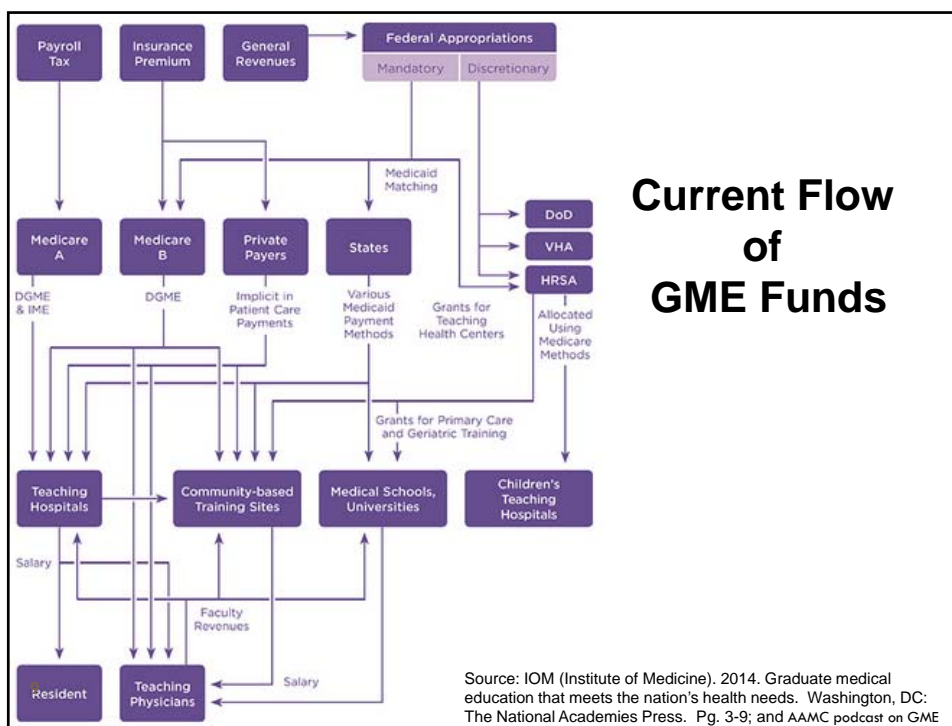
GME Financing

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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

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- Federal funding for GME began in 1965 as part of the Social Security Act
- When Congress established Medicare in 1965, it recognized that:
 - "Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program."

Source: 1965 Social Security Act (Senate Report No. 404, Pt. 1 89th Congress, 1st Sess. 36 [1965]; H.R. No. 213, 89th Congress, 1st Sess. 32 [1965])

Medicare GME Funding Components

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- **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

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- **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 DME Payment

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- The Balanced Budget Refinement Act (BBRA) of 1999 reduced the hospital to hospital variation in PRA by mandating that a hospital's PRA could not be less than 70 percent of the level of the national average PRA
- In 2000, the Benefits Improvement and Protection Act raised the minimum to 85 percent

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

Medicare IME Payment

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- IME is an additional payment a hospital receives on top of its normal traditional Medicare inpatient payment
- $\text{DRG Payment} \times [\text{Multiplier} \times ((1 + \text{IRB})^{0.405} - 1)]$
 - ▣ 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

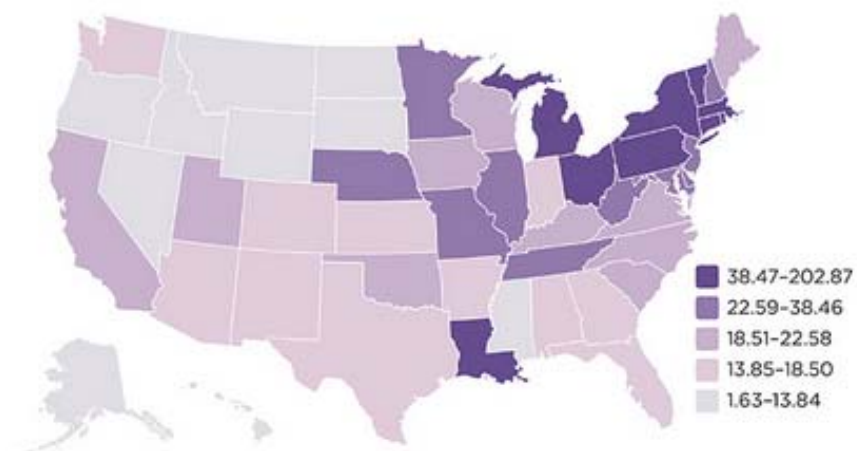
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- The Balanced Budget Act of 1997 implemented a cap on the number of resident FTEs for which a hospital could receive Medicare GME reimbursement
 - Based on the number of residents the hospital was training in 1996
 - “The geographic distribution of 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

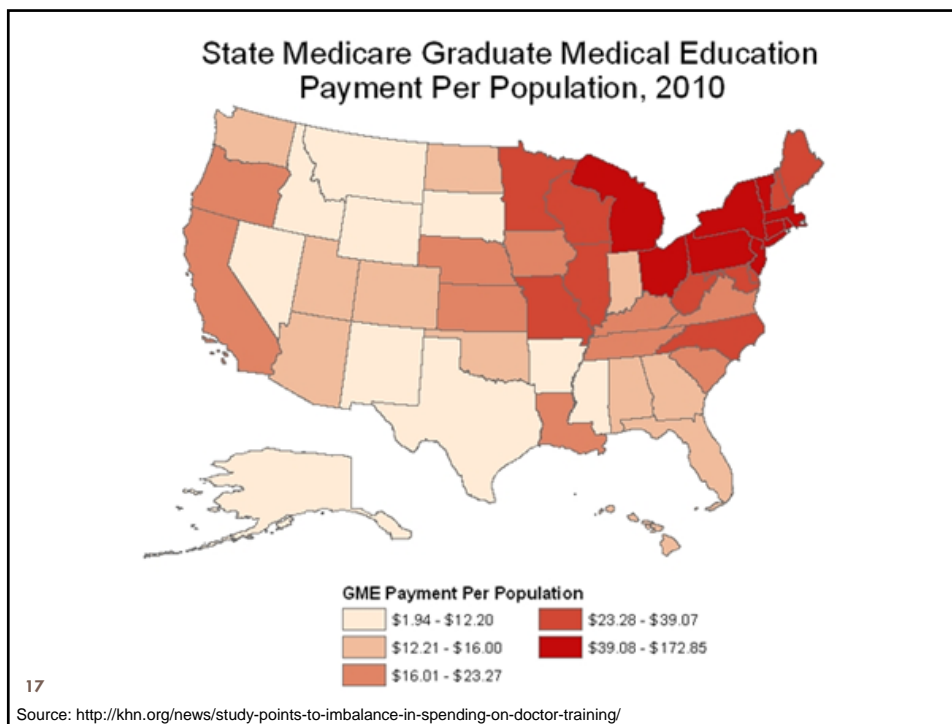
Source: IOM (Institute of Medicine). 2014. Graduate medical education that meets the nation's health needs. Washington, DC: The National Academies Press. Pg. 3-11

Number of Medicare-Funded Training Positions per 100,000 population (2010)

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Source: IOM (Institute of Medicine). 2014. Graduate medical education that meets the nation's health needs. Washington, DC: The National Academies Press. Pg. 3-13



Medicare Resident Caps

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- Hospitals have two resident caps, one for DME and one for IME
 - ▣ Numbers may be slightly different from each other based on rules regarding how residents were counted in 1996
- Rural hospitals received a cap based on 130% of the number of residents the hospital was training at that time, allowing for growth
- Some facilities do not have a Medicare cap
 - ▣ Critical access hospitals are paid at 101% of cost for their residency training and are not eligible for DME or IME payment
 - ▣ Inpatient Rehabilitation Facilities (IRF) and Inpatient Psychiatric Facilities (IPF) have their own separate rules and are not eligible for IME payment

Obtaining Slots Over One's Medicare Cap

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- Rural hospitals can increase their number of slots by starting a new residency program
- Urban teaching hospitals can start new rural training track residency programs and receive additional slots for the time that residents spend in the urban teaching hospital, as long as residents spend at least half their time in the rural setting
- Existing teaching hospitals can share their cap slots with other teaching hospitals by meeting certain requirements and then entering into GME affiliation agreements that explain the cap sharing arrangement
- Hospitals that have never been teaching hospitals before (referred to as naïve hospitals) can start new residency programs, and have up to 5 years to establish their residency cap
- If programs or hospitals close, there are ways other hospitals can receive temporary slots (to help train the residents that were in the closed program) or permanent slots that used to belong to the closed hospital

Medicare Resident Caps

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- 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
- There is no cap on dentist and podiatry residency slots because there were very few hospital-based resident programs in 1997 when the cap was established

Medicaid

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- 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

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

Medicaid

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- In 2012, Medicaid GME funding exceeded \$100 million in seven states (including Virginia)
 - ▣ Medicaid GME funding exceeded Medicare GME funding in North Carolina, South Carolina, and Washington

Challenges of the Current GME System in the U.S.

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- Outdated GME funding system
 - ▣ The Medicare DME payment is based on a hospital's costs in the 1980's which bears little resemblance to the amount of funding needed for current residency programs (e.g. due to increased cost of health benefits, malpractice insurance, technological teaching equipment, etc.)
 - ▣ Resident caps restrain growth of residency programs, including those in rural and/or underserved areas and in high need specialties
 - ▣ The GME funding system was created when hospitals were, for the most part, the only institutions that trained residents. As a result, it is a system of payments that are tied to hospital reimbursement. This results in difficulties for residency programs that currently, or wish to, provide training in community-based ambulatory settings where most physicians will be practicing
- Lack of governance, transparency and accountability of GME at both the federal and state level

Challenges of the Current GME System in the U.S.

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- Misalignment of the current GME system with the needs of the U.S. health care system and local communities
 - ▣ Shortage of physicians in primary care (and other high need specialties), especially in rural and underserved areas
- Insufficient workforce data and corresponding informed goals, to guide GME policy
- Concerns that the number of medical school graduates are outpacing the number of available residency positions
- Retention of residents in the state of their GME training

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Characteristics of GME in Virginia

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Medical Schools and Residency Programs

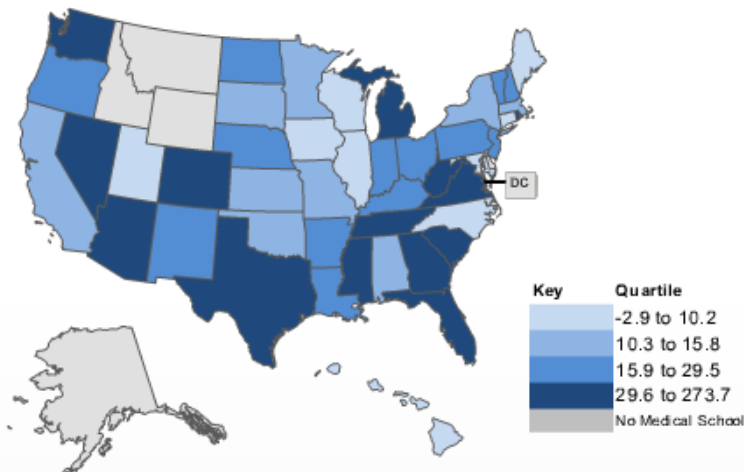
Virginia Undergraduate Medical Education (UME) School Enrollment

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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

Percent Change in Enrolled Students in Medical or Osteopathic Schools, 2002-2012



Virginia Residency Information

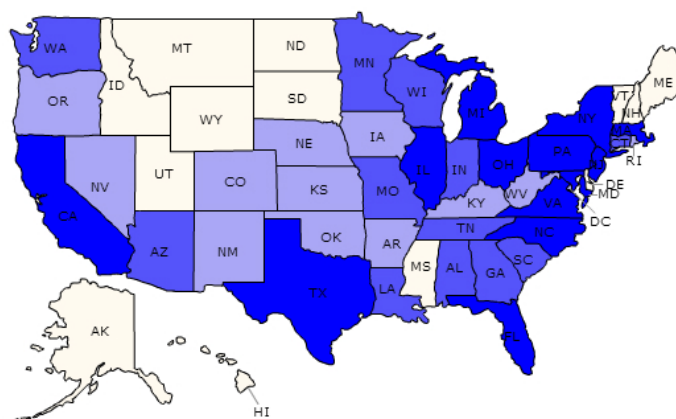
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- 2,745 residents and fellows are currently training in Virginia
 - ▣ 1,950 are reported as positions funded by Medicare and Medicaid
 - ▣ Remainder includes privately funded positions and those funded by the military and the Department of Veterans 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

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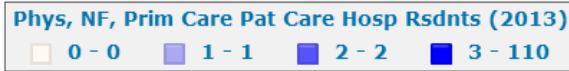
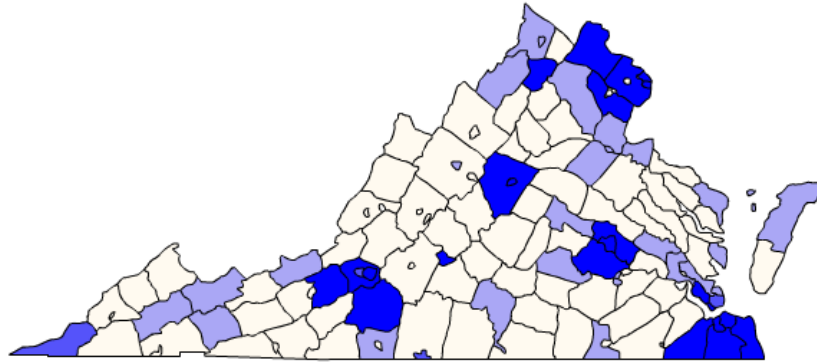


Phys, NF, Prim Care Pat Care Hosp Rsdnts (2013)
 33 - 181 182 - 418 419 - 768 769 - 5559

Source: <http://chrf.hrsa.gov/arfdashboard/ArfGeo.aspx>

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

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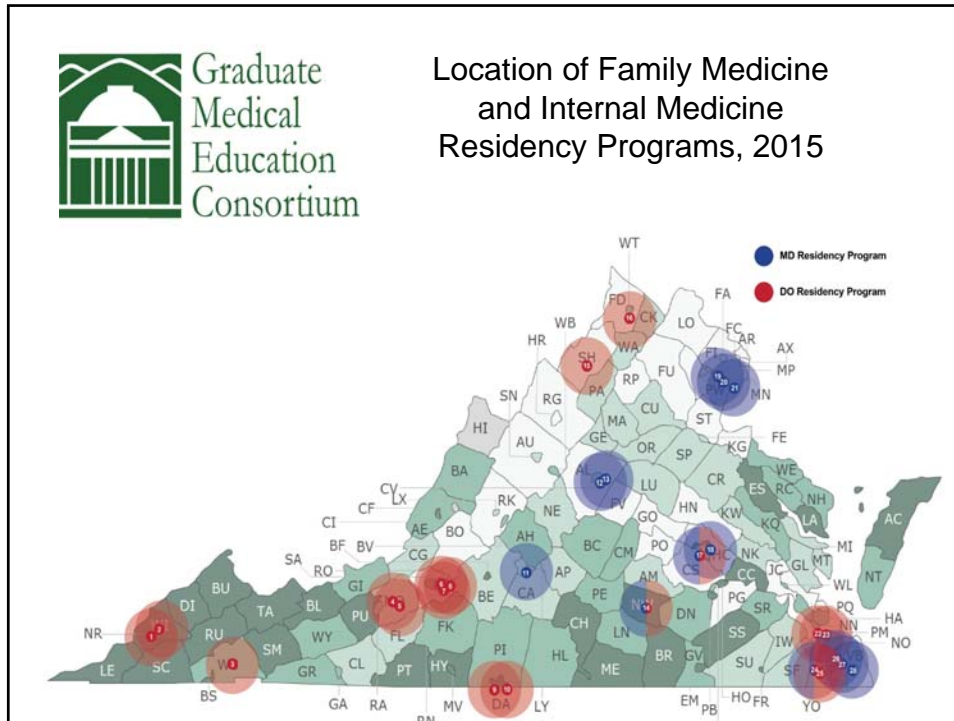


Source: <http://chrf.hrsa.gov/arfdashboard/ArfGeo.aspx>

Virginia Teaching Hospitals Medicare Actual Positions vs. Capped Positions, 2014

Facility	GME Cap	IME Cap	GME Positions Reported	IME Positions Reported	GME Positions Over (Under) Cap	IME Positions Over (Under) Cap
Bon Secours DePaul Medical Center	15.01	15.01	10.73	10.73	(4.28)	(4.28)
Carilion Medical Center	123.23	105.45	190.82	188.45	67.59	83.00
Centra Health	15.56	18	15.56	16.78	0.00	(1.22)
CJW Medical Center	6.61	6.86	8	7.82	1.39	0.96
Danville Regional Medical Center	57.43	57.43	49.82	49.69	(7.61)	(7.74)
Inova Fairfax Hospital	131.71	112.99	162.05	162.05	30.34	49.06
Inova Loudoun Hospital Center	0	0	0.27	0.27	0.27	0.27
Lewis-Gale Hospital Montgomery	37.15	37.15	34.33	34.33	(2.82)	(2.82)
Lonesome Pine Hospital	0	0	16.97	16.45	16.97	16.45
Norton Community Hospital	19.3	18.95	18.95	18.95	(0.35)	0.00
Maryview Hospital	16.34	16.34	15.75	15.75	(0.59)	(0.59)
Riverside Regional Medical Center	60.85	49.36	59.68	52.97	(1.17)	3.61
Sentara Leigh Hospital	9.04	8.92	11.73	11.73	2.69	2.81
Sentara Norfolk General Hospital	107.16	94.05	135.41	125.6	28.25	31.55
Sentara Obici Hospital	1.75	1.75	1.04	1.04	(0.71)	(0.71)
Sentara Princess Anne Hospital	2.94	3	4	4	1.06	1.00
Sentara VA. Bch. General Hospital	4.6	2	4.6	4.6	0.00	2.60
St. Francis Medical Center	20.09	20.09	19.61	19.61	(0.48)	(0.48)
St. Mary's Hospital	4.35	4.35	3.33	3.33	(1.02)	(1.02)
University of Virginia Medical Center	535.19	503.52	646.12	646.12	110.93	142.60
VCU Health System MCV Hospital	453.58	406.74	523.44	500.06	69.86	93.32
Virginia Hospital Center	31.14	29.3	30.86	30.86	(0.28)	1.56
Warren Memorial Hospital	8.53	8.53	8.41	8.41	(0.12)	(0.12)
Winchester Medical Center	8.1	8.18	8.1	8.1	0.00	(0.08)
Total	1669.66	1527.97	1979.58	1937.7	309.92	409.73

Source: acgme.org and osteopathic.org via VCOM



Primary Care Residencies-Family Medicine

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ACGME		ACGME/AOA		
		Approved	Filled	Per Year
University of Virginia Program	Charlottesville	24	24	8
Chippenham and Johnston-Willis Hospitals Program	Richmond	24	24	8
VCU (Falls Church) Program	Fairfax	24	24	8
Carilion Clinic-Virginia Tech Carilion School of Medicine Program (ACGME and AOA)	Roanoke	30	31	10
National Capital Consortium (Fort Belvoir Community Hospital) Program-Military	Fort Belvoir	45	42	15
Centra Health Program	Lynchburg	27	17	9
Eastern Virginia Medical School (Ghent) Program	Norfolk	24	18	8
Eastern Virginia Medical School (Portsmouth) Program	Portsmouth	18	16	6
Shenandoah Valley Health System/VCU Program (ACGME and AOA)	Front Royal	15	15	5
VCU/Riverside Regional Medical Center Program (ACGME and AOA)	Newport News	36	36	12
VCU-Bon Secours (St Francis) Program	Midlothian	18	18	6
VCU-Bon Secours Blackstone (rural)	Blackstone	6	4	6
AOA				
★ Johnston Memorial Hospital Program	Abingdon	18	6	6
Lewis Gale Hospital-Montgomery Program	Blacksburg	19	17	6
Danville Regional Med Center Program	Danville	24	16	8
Wellmont Lonesome Pine Hospital Program	Norton	24	19	8
Total		376	327	129

★ New Program

Source: acgme.org and osteopathic.org, via VCOM, and VCU Family Medicine Residency Program

Primary Care Residencies-Internal Medicine

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ACGME		ACGME/AO A Approved	Filled	Per Year
Naval Medical Center (Portsmouth) Program-Military	Portsmouth	41	40	13
University of Virginia Program	Charlottesville	101	98	30
Eastern Virginia Medical School Program	Norfolk	56	46	18
Virginia Commonwealth University Health System Program	Richmond	114	115	38
Carilion Clinic-Virginia Tech Carilion School of Medicine Program	Roanoke	66	54	22
AOA				
★ Johnston Memorial Hospital Program	Abington	12	1	4
Lewis Gale Hospital-Montgomery Program	Blacksburg	18	2	6
Danville Regional Med Center Program	Danville	45	32	15
Norton Community Hospital Program	Norton	30	24	10
Total		483	412	156

★ New Program

Source: acgme.org and osteopathic.org, via VCOM

Primary Care Residencies-Pediatrics

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ACGME Pediatrics		ACGME Approved	Filled	Per Year
University of Virginia Program	Charlottesville	35	35	11
Naval Medical Center (Portsmouth) Program-Military	Portsmouth	36	31	12
Eastern Virginia Medical School Program	Norfolk	66	65	22
Virginia Commonwealth University Health System Program	Richmond	48	48	16
Inova Fairfax Medical Campus/Inova Children's Hospital Program	Falls Church	39	41	13
Carilion Clinic-Virginia Tech Carilion School of Medicine Program	Roanoke	18	18	6
Internal Medicine/Pediatrics				
Virginia Commonwealth University Health System Program	Richmond	24	21	7
Total		266	253	87
TOTAL PRIMARY CARE RESIDENTS		1125	992	372

Source: acgme.org and osteopathic.org, via VCOM

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

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Source: CMS Hospital Cost Reports/HCRIS Files 2012

Medicaid GME Payment Amounts by the Top 15 States, 2012

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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.**

Inpatient Hospital GME Payments, According to Medicaid Financial Management Reports, for FY 2010-2013

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Fiscal Year	Federal Share	State Share	Total
2010	\$75,965,959*	\$47,375,428	\$123,341,387
2011	\$92,864,584*	\$68,670,398	\$161,534,982
2012	\$116,916,401	\$116,916,398	\$233,832,799
2013	\$135,315,780	\$135,315,778	\$270,631,558

*The FMAP was temporarily enhanced under ARRA for FY2009-FY2011

Sources: Medicaid Financial Management Reports, FY2010, FY2011, FY2012, FY2013

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 PRINCESS 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 PRINCESS 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

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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

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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

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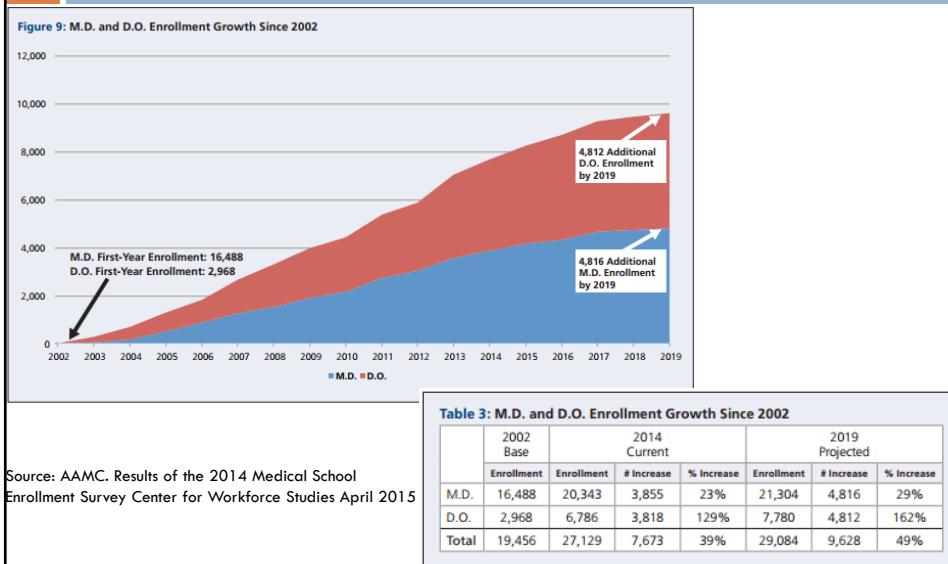
- The Virginia State Budget (FY 2015-2016) includes the following GF appropriations for the support of family medicine residency programs at Virginia Commonwealth University, University of Virginia, and Eastern Virginia Medical School
 - VCU: \$4,336,607
 - UVA: \$1,393,959
 - EVMS: \$722,146
- Residency 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

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Availability of Residency Positions

U.S. Medical School Enrollment Growth, 2002-2019

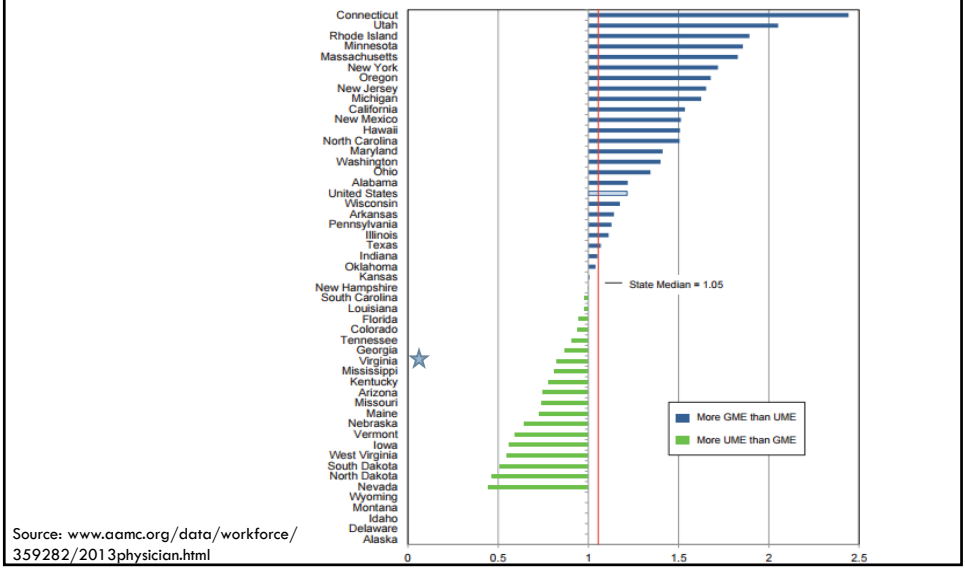


Change in the Number of Medical Schools, Medical School Enrollment, and Applicants to GME Programs, 2002 - 2012

	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



Retention of Residents in Virginia

Virginia Physician Retention, 2012

51

	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

Location of Education and Training of Physicians in Virginia, 2012

Education / Training	Virginia	Border State	Virginia & Border States	NY & PA	Regional	International
High School	20%	12%	32%	15%	47%	20%
Undergraduate	19%	16%	35%	14%	49%	17%
Medical School	20%	18%	38%	13%	51%	21%
Residency	27%	23%	50%	17%	67%	NA

Regional:
 Virginia
 Washington DC
 New York
 Pennsylvania
 Maryland
 North Carolina

Location of Medical School and Residency for Virginia Physicians Licensed in the Past Five Years, 2014

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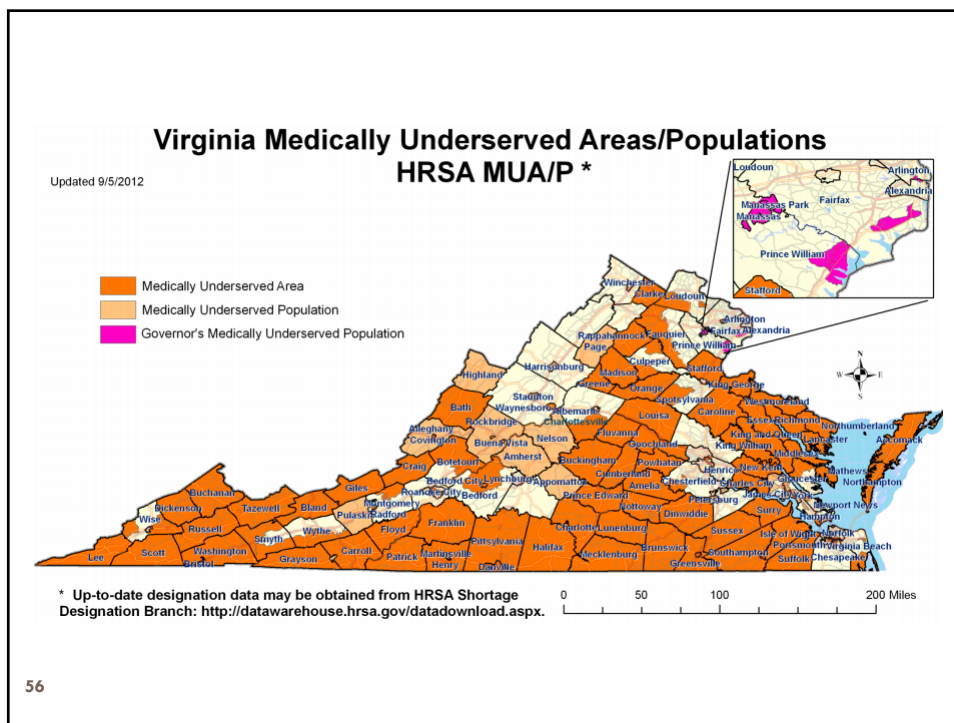
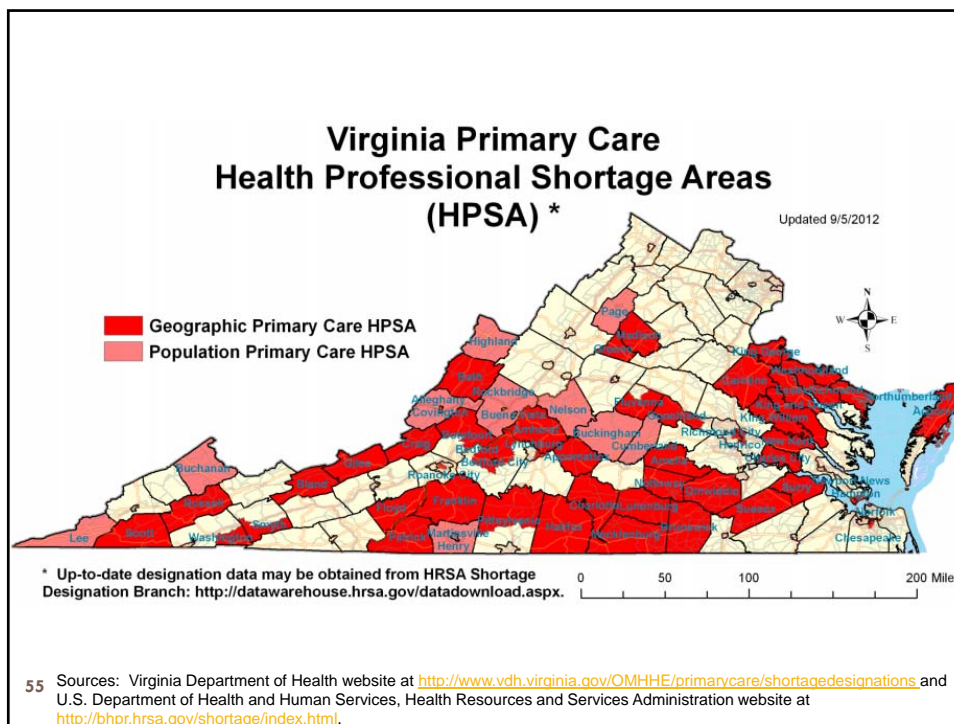
Rank	Licensed in the Past 5 Years			
	Medical School	#	Initial Residency	#
1	Outside U.S./Canada	1,219	Virginia	1369
2	Virginia	894	New York	531
3	Pennsylvania	345	Washington, D.C.	397
4	New York	278	Pennsylvania	344
5	Washington, D.C.	251	Maryland	331
6	Maryland	249	Ohio	199
7	Ohio	162	North Carolina	196
8	North Carolina	147	Michigan	183
9	Illinois	126	California	140
10	Florida	125	New Jersey	131

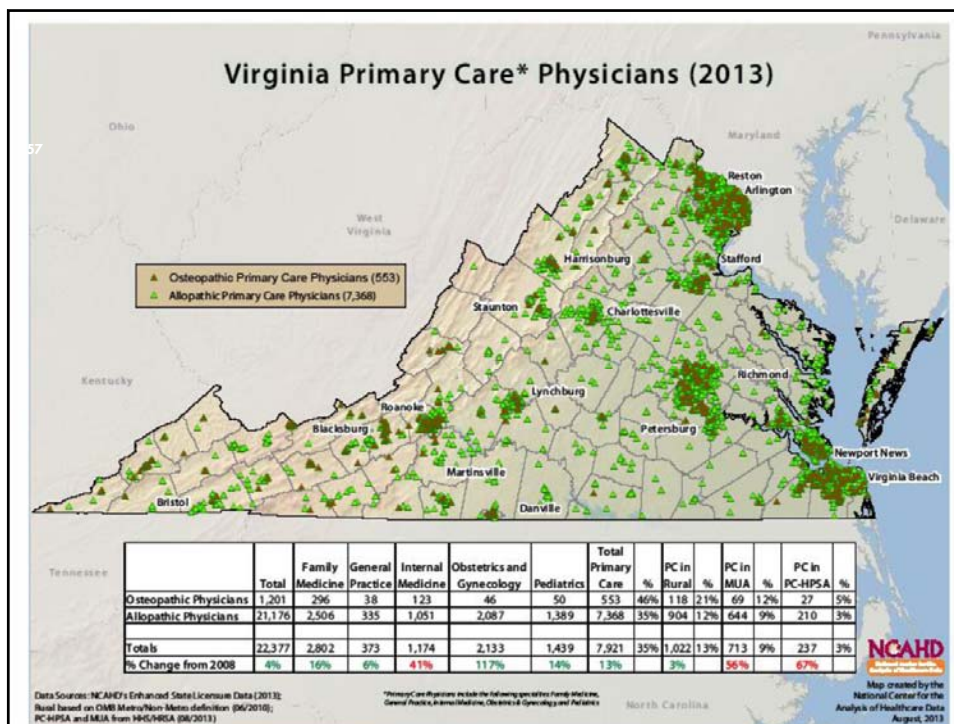
Among physicians who have been licensed in the past five years, 17% received their medical degree in Virginia, while 26% completed their initial residency in the State.

Source: Va. Healthcare Workforce Data Center

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Physicians in Rural and/or Underserved Areas of Virginia





Physicians in Rural and/or Underserved Areas of Virginia

58

- 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% West Virginia: 40.7%
 - Kentucky: 33.6% Tennessee: 26.7%
 - North Carolina: 35.3% 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

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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	



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

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Considerations for Improving Graduate Medical Education in Virginia

Address the Needs of Rural and Underserved Areas in Virginia

61

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

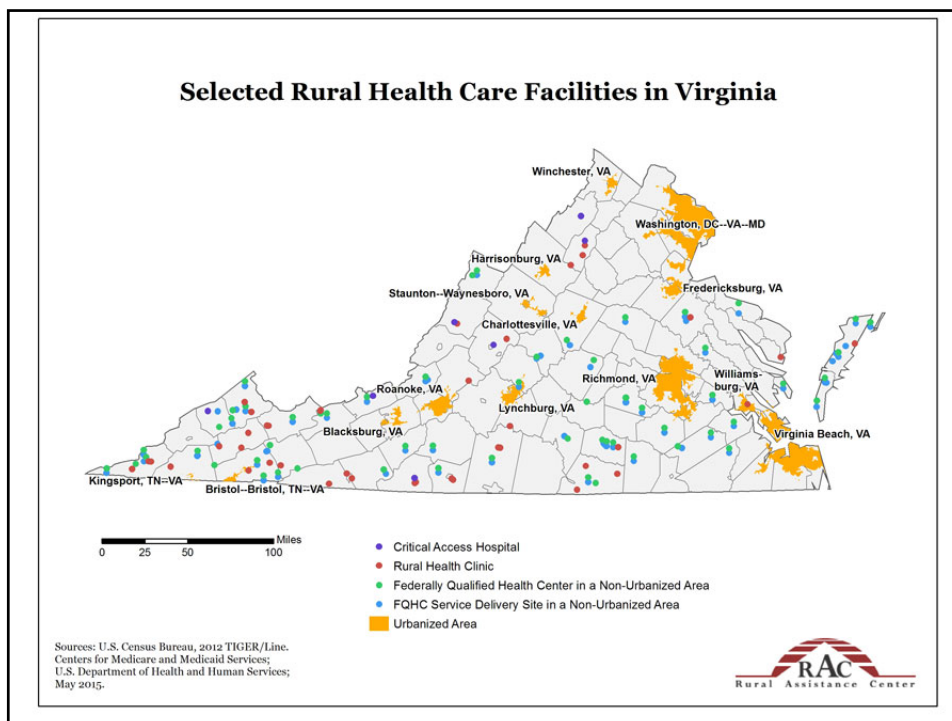
- As mentioned earlier, hospitals that have not trained residents (referred to as naïve hospitals) can start new residency programs and have up to 5 years to establish their residency cap for Medicare and Medicaid GME funding
 - While these programs are sustainable like other residency programs once 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

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- 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/>



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
- Centra Lynchburg
- 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

68

- 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

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- 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

70

- 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

71

- 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

72

- 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

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

State Loan Repayment Program (SLRP) Funding, 2015

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Total VDH/SLRP Funds	\$317,200
New Funds	\$150,000
Carry-Over Funds	\$167,200
Total Virginia Health Care Foundation Match Funds	\$120,000
Applications Received	
Approved	11
No Funds Available	4
(Requested additional \$90,000, was not approved)	
No Match Funds Available	3
Declined/Ineligible/NHSC grant recipient	7
SLRP Funds Remaining	\$2,800

Source: VDH 2015 State Loan Repayment Program Report

2015 SLRP Recipient Details

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Specialty	Award Type	Facility Location	Facility Type	Total Award
General Practice Dentist	New, 2 year	Roanoke, VA	Non-profit	\$ 100,000
Family Nurse Practitioner	New, 2 year	Luray, VA	Non-profit	\$ 60,000
General Psychiatry	New, 2 year	Bluefield, VA	Public/State Institution	\$ 50,000
General Psychiatry	Renewal, 1 year	Wytheville, VA	Public/State Institution	\$ 35,000
General Practice Dentist	New, 2 year	Abingdon, VA	Non-profit	* \$ 60,000
Family Medicine	New, 2 year	Cape Charles, VA	Non-profit	* \$ 60,000
Pediatric Dentist	New, 2 year	Roanoke, VA	Non-profit	* \$ 60,000
Family Medicine	New, 2 year	Clarksville, VA	Non-profit	\$ 50,000
Health Service Psychologist	New, 2 year	Roanoke, VA	Non-profit	* \$ 60,000
Family Medicine	New, 2 year	South Boston, VA	Non-profit	\$ 50,000
Family Nurse Practitioner	New, 2 year	Fredericksburg, VA	Non-profit	\$ 40,000
Pharmacist	New, 2 year	Nathalie, VA	Non-profit	\$ 9,750

Source: VDH 2015 State Loan Repayment Program Report

*Match provided by Virginia Health Care Foundation

2015 SLRP Unfunded Eligible Applicants

75

Specialty	Facility Location	Facility Type	Match Funding Available
No SLRP Funds Available			
Family Nurse Practitioner	Fredericksburg VA	Non-profit	\$20,000
Primary Care, DO	Midlothian, VA	Non-profit	\$32,500
General Psychiatry	Abingdon, VA	Public/State Institution	\$17,500
Family Nurse Practitioner	Charlottesville, VA	Non-profit	<u>\$20,000</u>
			\$90,000
No Community/Facility Match Funds Available			
General Practice Dentist	Asheville, NC	Non-profit	--
Family Nurse Practitioner	Ewing, VA	Non-profit	--
Family Nurse Practitioner	Grundy, VA	Non-profit	--

Source: VDH 2015 State Loan Repayment Program Report

Establish Workforce and GME Data Collection Program

76

- 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

77

- 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

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- **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

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- **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

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- **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

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- **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

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- **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

Public Comments

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- Written public comments on the proposed options may be submitted to JCHC by close of business on October 28, 2015. Comments may be submitted via:
 - E-mail: sreid@jchc.virginia.gov
 - Facsimile: 804-786-5538
 - Mail: Joint Commission on Health Care
P.O. Box 1322
Richmond, Virginia 23218

- Comments will be summarized and included in the Decision Matrix which will be discussed during the JCHC meeting on November 4, 2015.

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Joint Commission on Health Care
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P. O. Box 1322
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