

Athens Regional Medical Center

Graduate Medical Education Feasibility Assessment

Final Report

January 7, 2008

ECG

MANAGEMENT
CONSULTANTS

ECG MANAGEMENT CONSULTANTS, INC.

100 Cambridge Street, Suite 2001, Boston, MA 02114-2509

telephone 617.227.0100 *fax* 617.227.0042

e-mail ecg@ecgmc.com *web site* www.ecgmc.com

SEATTLE • BOSTON • WASHINGTON D.C. • SAN DIEGO • ST. LOUIS

TABLE OF CONTENTS

	<u>Page</u>
I. Executive Summary	2
II. Methodology	4
A. Steering Committee and Project Participants	4
B. Data Review and Interviews	4
C. Steering Committee Meetings	5
III. ARMC Physician Need Analysis.....	8
A. Categories	8
B. Methodology	9
C. Findings.....	9
D. Conclusions.....	11
IV. Benefits of GME.....	13
A. Benefits to Communities.....	13
B. Benefits to Teaching Hospitals.....	13
V. GME Financing	16
A. Reimbursement for Teaching Hospitals.....	16
B. GME Reimbursement for New Teaching Hospitals	18
C. State Funding of GME in Georgia.....	18
VI. Proposed Collaborative Model for GME in Northeast Georgia	21
Appendix A – Brief List of Key Hospital Attributes	
Appendix B – Excerpted Material from Steering Committee Meetings	

I. Executive Summary

I. Executive Summary

The state of Georgia is confronted by an expected shortage of physicians in the coming years. The development of graduate medical education (GME) programs, which are necessary to train physicians in various medical and surgical specialties upon graduation from medical school, is an essential response to this challenge. Accordingly, in November and December, 2007, a steering committee comprising the senior leadership of Athens Regional Medical Center (ARMC), Northeast Georgia Health System (NGHS), and St. Mary's Health Care System (SMHCS) was assisted by ECG Management Consultants, Inc., in conducting a preliminary feasibility assessment of each hospital's capability to participate in GME. In addition, the hospital chief executive officers (CEOs), through the steering committee, considered the possibilities for a collaborative arrangement among the three institutions and potential academic partner(s) for establishing new GME programs in the region.

The team accomplished the following objectives:

- For each hospital, conducted a preliminary assessment of the organizational feasibility, operational capacity, and cultural viability of participating in GME.
- Determined the desire to explore in more detail a collaborative GME arrangement among the three hospitals.
- Based on this determination, outlined a conceptual framework for a collaborative GME arrangement, comprising principles, objectives, and imperatives for organization, governance, finance, and decision making.

More specifically, the steering committee reached the following conclusions during the process:

Physician workforce studies completed independently by each hospital are consistent and project shortages emerging in many specialties in the next 10 years. All three participating hospitals have in recent years independently analyzed future physician supply needs for their institutions. Although their projections differ somewhat in methodology and the time frame analyzed, their conclusions are essentially in agreement about a looming shortage of physicians in the region that is already being experienced in several medical fields of specialty. The physician shortages predicted by these hospitals for the coming decade will affect a combined service area involving multiple counties in a region of Georgia experiencing very rapid population growth. Addressing these shortages, or failing to do so, will have direct implications for healthcare statewide.

The establishment of GME programs in northeast Georgia would serve to improve concerns regarding physician supply. Residents graduating from GME programs tend to practice in the service area of the program in which they train. Importantly, the strategy explored in the present study, to create new residency training programs in the region, will not in itself meet the projected physician supply need. However, in addition to creating a cohort of new physicians with strong ties to the Georgia medical community, these new residency programs will: (1) help in recruiting other

physicians to Georgia who seek careers in association with teaching hospitals; (2) provide a training environment for third- and fourth-year medical students in support of medical school expansion; and (3) offer opportunities for other hospitals to participate as consortium members in the development of additional new residency programs in the future.

The three hospitals individually and collectively can provide a clinical environment conducive to the operation of high-quality GME programs. Based on a high-level review of clinical volumes and service mix, as well as the educational requirements of various GME programs, each hospital CEO concluded that his individual organization can provide adequate patient care volumes and an appropriate patient mix in support of a robust GME training experience. GME programs of interest to the hospitals have not been finalized, but programs considered included:

- Internal medicine.
- Family medicine.
- Obstetrics and gynecology (OB/GYN).
- Pediatrics.
- General surgery.
- Psychiatry.
- Emergency medicine.

There is a seemingly supportive medical staff environment and physicians who have expressed interest in serving as faculty to GME programs. Interviews and meetings with medical staff representatives conducted by ECG, as well as the firsthand knowledge of each hospital's senior leadership team, indicate that there is preliminary interest among selected physicians to serve as faculty. Without high-quality faculty and physician leadership, new GME programs at these institutions would face insurmountable challenges. The university environment of Athens in particular appears to contribute to a general level of support for academics in the physician community. Interviews with representatives of the Medical College of Georgia (MCG), Philadelphia College of Osteopathic Medicine (Suwanee, Georgia, campus), and the University of Georgia indicate support for developing high-quality faculty for the GME programs. Ultimately, physician willingness to serve as faculty to GME programs will depend on program organization, the specific individual requirements for physician teaching effort, the impact of those requirements on the efficiency of physician clinical practice, and the associated financial arrangements for program administration and teaching.

A medical education consortium model for organizing, governing, managing, and financing GME in the region may represent the best opportunity to meet institutional, regional, and statewide objectives and imperatives. A view across the country reveals a variety of models and arrangements whereby hospitals and medical schools affiliate and participate in GME. One such model is a medical education consortium through which hospitals and their academic partner(s) formally organize, typically through incorporation, and unite to more effectively manage, operate, and finance GME programs across their institutions. Consortia models tend to promote a community-oriented focus toward GME (as opposed to an institution-centric bias), foster the development of programmatic economies and administrative efficiencies, and enable coordinated planning and financing of the educational enterprise. The project participants identified the major

attributes of a potential consortium model for northeast Georgia, and they believe such a model may best create opportunities to meet institutional, regional, and statewide objectives and imperatives.

Significant financial hurdles will need to be resolved to promote establishment of GME programs in northeast Georgia and foster their ongoing financial viability. The costs of GME include resident and faculty wages and benefits, program administration and infrastructure requirements, and the institutional and professional inefficiencies created by medical education. The Medicare program is the principal source of funding and reimbursement for the costs of GME in the United States. In recent years and beginning with the Balanced Budget Act of 1997 (BBA), Congress has generally constrained and reduced financial support for the nation's GME programs through caps and reductions in payments to teaching hospitals. While this situation has created significant pressure on existing teaching hospitals with long-standing GME programs, it presents a unique set of challenges to community hospitals seeking to establish new GME programs and become teaching hospitals. Existing legislation provides a time-limited and financially narrow opportunity for new teaching hospitals to establish eligibility for GME reimbursement, and modeling suggests such reimbursement may be significantly below levels required to adequately support the ongoing and one-time start-up costs of new GME programs. Accordingly, the hospitals and their academic partner(s), the state of Georgia, and the local and regional communities will need to explore creative solutions to identify and secure appropriate funding for GME programs in northeast Georgia.

Participation in GME is a mission-changing decision for each hospital, requiring deliberative and comprehensive planning, substantial constituency support, and requisite corporate approvals. While potentially creating a range of tangible and intangible benefits for each hospital, the operation of GME programs has transformational implications that affect clinical service design, care delivery models, medical staff and nursing relations, patient perceptions, and institutional resource utilization. Accordingly, a comprehensive planning effort is required that defines specific programs, resident complements, faculty arrangements, academic affiliations, financial implications, and so forth. Such planning will best be informed through broad participation of each hospital's relevant constituencies, as well as potential academic partners. A comprehensive planning effort will create greater visibility regarding the specific challenges that will require strategic, organizational, operational, financial, and political solutions. Ultimately, the willingness of each hospital to commit to, and the associated level of, participation in GME will be predicated upon the sufficiency of the identified solutions.

* * * * *

ARMC appreciates the opportunity provided by the Georgia Board for Physician Workforce to explore the prospects of establishing GME programs in northeast Georgia through this project. While serious challenges exist, the spirit of collaboration demonstrated among each hospital's leadership teams, as well as the potential for establishing a GME consortium to address the important physician workforce issues that confront our hospital, the region, and the state of Georgia, compels further planning. ARMC looks forward to continued participation in such efforts.

II. Methodology

II. Methodology

A. Steering Committee and Project Participants

To accomplish the project's strategic goals within an aggressive time frame, a steering committee was convened comprising the CEOs and other senior leaders of ARMC, NGHS, and SMHCS, as well as senior leadership from the University of Georgia College of Public Health. Members of the steering committee included:

- Representing ARMC:
 - » Mr. John Drew, President and CEO.
 - » Stephen Lucas, M.D., Chief Medical Officer.

- Representing Northeast Georgia Medical Center (NGMC):
 - » Mr. Jim Gardner, President and CEO.
 - » Ms. Tracy Vardeman, Vice President for Strategic Planning.

- Representing SMHCS:
 - » Mr. Thomas Fitz, President and CEO.
 - » Mr. Marty Hutson, Chief Financial Officer.

- Representing the University of Georgia:
 - » Eric Dahl, Ph.D., Associate Dean, College of Public Health.
 - » Ms. Alison McCullick, Program Coordinator for Health Initiatives.

Broader participation in the project was accomplished through individual interviews with hospital administrative and physician leadership from each institution, as well as leadership from the University of Georgia, MCG, and the Philadelphia College of Osteopathic Medicine (Suwanee, Georgia, campus). In addition, there were several group meetings of members of the medical staffs from each hospital to discuss the project, assess the level of understanding relative to GME, and determine preliminary willingness to consider participation in GME.

B. Data Review and Interviews

The first phase of the project encompassed a review of data from ARMC, NGHS, and SMHCS. As available, participants provided data pertinent to assessing the feasibility of establishing GME at their institutions, which established a foundation for subsequent project activities. Specific areas of focus included:

- Inpatient and outpatient clinical facilities, including locations, numbers of beds, services provided, and volumes.
- Clinical program strengths.
- Physician need analyses and medical staff development plans.
- Medicare cost reports.
- Planning documents.

Concurrently, individual interviews were conducted with each steering committee member as well as a variety of other individuals recommended by the steering committee. Interview topics included:

- Desire to participate in GME and collaborate on GME.
- Understanding of the implications of participation.
- Impediments to participation.
- Critical issues that must be considered over the course of this preliminary feasibility assessment.

C. Steering Committee Meetings

The steering committee met four times during November and December to conduct this preliminary feasibility assessment and to determine preferred GME arrangements in a collaborative manner. Meeting dates and agendas were:

1. November 17 – Project Initiation

The first meeting of the steering committee addressed the consulting team’s baseline findings and established a context for future project efforts. Agenda items included:

- Discussion and validation of preliminary interview and data findings.
- A review of the medical education process.
- The process of institutional and program-specific accreditation.
- Sources of financing for medical education.
- Identification of the range of GME organizational models.

2. November 28 – GME Program Attributes

The second meeting explored the required elements of a successful GME collaboration among the participating institutions. Agenda items included:

- Overview of current GME programs in Georgia.
- Key considerations for institutions sponsoring and/or participating in GME.
- Attributes of successful multiparty affiliations for GME.
- Preliminary identification of desired GME programs.

3. December 6 – Requirements to Establish New GME Programs in Northeast Georgia

The third meeting addressed the feasibility of offering the desired GME programs identified in the previous meeting, as well as a potential structure for the GME enterprise. The agenda included:

- Volume assessments for desired GME programs.
- Characteristics and performance of GME consortia.
- Suggested straw man model for a GME consortium in northeast Georgia.

4. December 14 – Conclusions and Next Steps

The final meeting revisited and confirmed the desired structure of a GME consortium and explored the issues surrounding funding of such an enterprise. Specific agenda items included:

- Refined straw man model for the Northeast Georgia Graduate Medical Education Consortium (NGMEC).¹
- Potential state and federal reimbursement opportunities.
- Other funding requirements/opportunities.
- Next steps.

* * * * *

APPENDIX A to this report provides a brief list of key attributes of each of the hospitals that may be conducive to the operation of GME programs. APPENDIX B provides excerpted material from steering committee documents.

¹ Described in detail at the conclusion of this report.

III. ARMC Physician Need Analysis

III. ARMC Physician Need Analysis

A. Categories

ARMC provided the consulting team with a detailed physician need assessment for its clinical services in FY 2018. The assessment categories included:

- Primary care.
 - » Family practice and general practice.
 - » General internal medicine.
 - » OB/GYN.
 - » General pediatrics.
- Medical specialties.
 - » Allergy and immunology.
 - » Cardiology.
 - » Dermatology.
 - » Endocrinology.
 - » Gastroenterology.
 - » Hematology/oncology.
 - » Infectious disease.
 - » Nephrology.
 - » Neurology.
 - » Pulmonology.
 - » Rheumatology.
- Surgical specialties.
 - » Cardiovascular.
 - » General.
 - » Neurosurgery.
 - » Ophthalmology.
 - » Otolaryngology.
 - » Plastic.

- » Thoracic.
- » Urology.
- » Vascular.
- Other specialties.
 - » Occupational medicine.
 - » Physical medicine and rehabilitation (PM&R).
 - » Psychiatry.
 - » Radiation oncology.
- Hospital-based/staff specialties.
 - » Anesthesiology.
 - » Critical care.
 - » Emergency medicine.
 - » Neonatology and perinatology.
 - » Pathology.
 - » Radiology.

B. Methodology

ARMC assessed its needs based on a comparison of its existing physician inventory to projected FY 2018 needs in these categories and subspecialties. The projections represent the median values of five widely used physician need indicators:

- Graduate Medical Education National Advisory Committee (GMENAC).
- Hicks and Glenn.
- L+S FFS.
- American Medical Association (AMA) (national).
- AMA (Georgia).

C. Findings

Based on a comparison to median projected physician needs in 2018, ARMC projects a need to expand its existing medical staff across all service-area counties by:

Primary Care – 298.52 Physicians

The projected physician need increases include:

- 124.9 family and general practitioners.
- 86.3 internists.
- 31.3 OB/GYNs.
- 56 general pediatricians.

Medical Specialties – 33.5 Physicians

The projected physician need increases include:

- 2.9 allergist/immunologists.
- 6.7 cardiologists.
- 3.7 endocrinologists.
- 9.7 gastroenterologists.
- 7.8 hematologist/oncologists.
- 5.3 infectious disease specialists.
- 3.5 neurologists.
- 3.3 rheumatologists.

Projected declining physician needs are:

- -3.5 dermatologists.
- -3.2 nephrologists.
- -2.7 pulmonologists.

Surgical Specialties – 121.3 Physicians

The projected physician need increases include:

- 44.2 general surgeons.
- 8.7 cardiovascular surgeons.
- 6.1 neurosurgeons.
- 14.5 ophthalmologists.

- 21.2 orthopaedic surgeons.
- 10.9 otolaryngologists.
- 0.4 plastic surgeons.
- 4.6 thoracic surgeons.
- 8.2 urologists.
- 2.7 vascular surgeons.

Other Specialties – 60.7 Physicians

The projected physician need increases include:

- 1.6 occupational medicine specialists.
- 8.5 PM&R specialists.
- 45.3 psychiatrists.
- 5.3 radiation oncologists.

Hospital-Based/Staff Specialties – 54.2 Physicians

The projected physician need increases include:

- 27.2 anesthesiologists.
- 3.1 critical care specialists.
- 16.1 pathologists.
- 20.3 radiologists.

Projected declining physician needs are -15.3 emergency medicine. However, statewide as well as regional needs for board-certified, emergency medicine specialists are important (as opposed to meeting emergency medicine needs with internists and other physicians).

D. Conclusions

By any standard, ARMC's projected physician needs over the next decade are daunting. It is important to note that the values reported above do not account for physician attrition over the same period of time, which will add to the system's overall recruitment needs. While it will be impossible to meet all of these needs via regional GME programs over the next 10 years, it is equally unlikely that recruitment from other regions and programs alone will lead to an adequate physician supply. Therefore, a development approach involving both recruitment and increased GME opportunities is likely to prove most effective for ARMC.

IV. Benefits of GME

IV. Benefits of GME

A. Benefits to Communities

Offering high-quality GME programs can serve as a productive source of physicians committed to the communities and states that host their training. The percentage of active Georgia physicians who completed GME training in state is approximately 50 percent, ranking Georgia 14th out of 50 states for retention of physicians after residency and/or fellowship training.² This implies a strong disposition on the part of Georgia-trained residents to join hospital staffs and private practices in the state.

The limiting factor for effectiveness of GME as a physician workforce enhancement mechanism in Georgia appears to be the scarcity of such opportunities. According to the 2006 National GME Census,³ the state ranks 37th out of 50 for the number of physicians enrolled in ACGME-accredited residency and fellowship programs, with a total of 1,942 residents and fellows representing 20.7 training physicians per 100,000 population. While in-state GME opportunities have increased by 4.2 percent over the past decade, this growth is substantially below the national average growth rate of 7.1 percent over the same period,⁴ and even further below the anticipated growth in need implied by the AAMC's recent call for a 30 percent increase in medical school enrollment between 2002 and 2012.⁵

Communities hosting vibrant GME programs may enjoy benefits in addition to those related to physician workforce, including an enhanced economy resulting from the increased presence of medical research and practice.

B. Benefits to Teaching Hospitals

Medical students and residents depend on the participation of hospitals for clinical clerkships and GME training. Hospitals are participants in the country's system of medical education because teaching hospitals derive a number of benefits from medical education programs. For example:

- The presence of high-quality residents fosters recruitment and retention of high-quality physicians who want to practice in a teaching hospital and participate in medical education.
- Graduating residents who subsequently practice in the hospital's service area typically admit and refer to the hospital at which they trained.

² AMA Physician Masterfile, January 2007.

³ Based on population estimates obtained from the U.S. Census Bureau.

⁴ *Journal of the American Medical Association (JAMA)*, September 5, 2007 – Vol. 298, No. 9. Appendix II, Table 4.

⁵ AAMC *Statement on the Physician Workforce*, June 2006.

- Teaching hospital status affords the hospital a positive and unique distinction in the marketplace.
- The training programs tend to ensure that the hospital and its medical staff remain up to date with the latest medical advances.
- The educational model may enhance the quality of care delivered at the hospital as a result of the use of patient care teams that include attending physicians, residents, medical students, and others.
- Residents offer a valuable patient care resource to the hospital by, for example, providing evening and weekend coverage of inpatients.
- Coverage provided by residents positively affects hospital/physician relations, since physicians tend to enjoy the support of residents.
- The existence of medical education programs affords the hospital the opportunity to attract selected subspecialist physicians and thereby offer subspecialty care unavailable at the typical nonteaching hospital.
- The presence of full-time faculty physicians may enable the hospital, community physicians, and their patients to participate in important clinical research projects.

The above benefits create significant strategic advantages for teaching hospitals and their physicians, particularly when the medical education programs are aligned with clinical delivery system strategies.

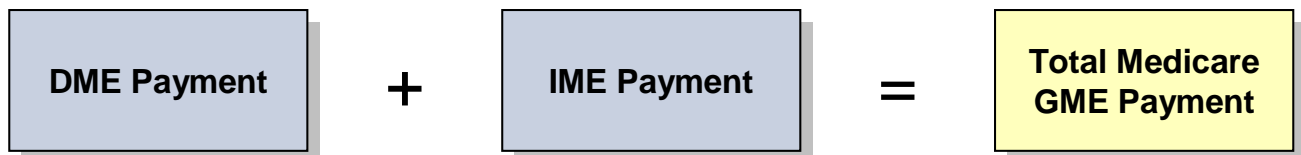
V. GME Financing

V. GME Financing

This section provides a brief overview of the reimbursement available to teaching hospitals related to medical education.

A. Reimbursement for Teaching Hospitals

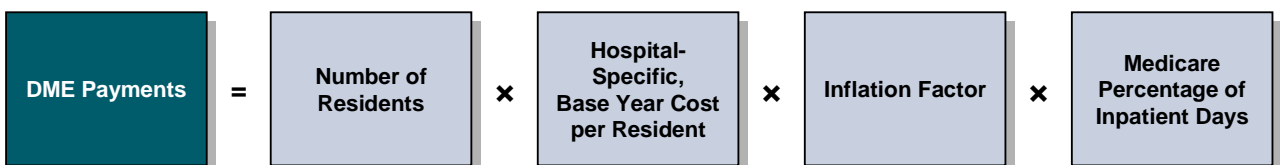
Medicare reimburses teaching hospitals for a portion of the direct and indirect costs of providing GME training through two mechanisms: direct medical education (DME) payments and indirect medical education (IME) payments.



- To recognize the direct GME-related costs incurred by the teaching hospital.
- Medicare's share of direct:
 - » Resident salary and fringe benefits.
 - » Faculty compensation for resident teaching and supervision.
 - » Other direct, allowable costs.
- To recognize the indirect costs of GME programs borne by the teaching hospital due to inefficiencies.
- To compensate teaching hospitals for higher inpatient costs due to patient severity of illness not fully captured by diagnosis related groups (DRGs).

DME payments are intended to cover the direct costs incurred by hospitals that sponsor GME programs. Direct costs include resident salary and benefits, faculty compensation for teaching and supervision of residents, and administrative overhead.

DME Payment Calculation

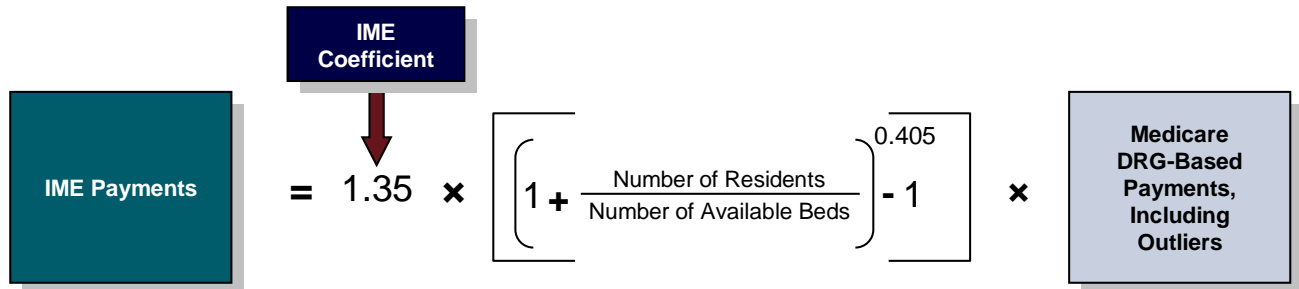


It is noteworthy that in 1997, Congress set limits on the number of reimbursable residents that could be counted for calculating DME payments. This created a financial disincentive for teaching hospitals to increase the number of physicians in training.

IME payments are intended to cover the indirect costs incurred by teaching hospitals. Indirect costs include inefficiencies related to longer lengths of stay, additional use of ancillary services, additional duties imposed on staff, and so forth. Since IME reimbursement is largely determined by a coefficient set by the Centers for Medicare & Medicaid Services (CMS), it is intended to reflect the

percentage by which teaching hospitals' costs of care increase due to the presence of GME programs and is built into hospitals' DRG rates.

IME Payment Calculation



The 1997 congressional legislation that placed limits on the number of residents that could be counted for calculating DME payments also contained limits on the number of residents that could be counted for calculating IME payments, creating further financial disincentives for GME program growth.

It should be noted that there is often significant confusion regarding the purpose of IME payments. AAMC, in a publication titled *Medicare Payments with an Education Label: Fundamentals and the Future*,⁶ may have explained it best:

“The IME adjustment carries a misleading name because its purpose is broader than GME. It compensates teaching hospitals for their higher inpatient costs due to patient severity of illness not fully captured by the DRG patient classification system. Additionally, there are higher operating costs associated with the presence of GME programs. Indirect costs cannot be specifically quantified; they can only be estimated through statistical analysis.”

This is supported by the following congressional statement:⁷

“This adjustment is provided in light of doubts... about the ability of the DRG classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with teaching residents... The adjustment for indirect medical education costs is only a proxy to account for a number of factors that may legitimately increase costs in teaching hospitals.”

⁶ Published by AAMC, Ms. Linda E. Fishman, Associate Vice President, Division of Health Care Affairs, 1996.

⁷ House Ways and Means and Senate Finance Committees' reports accompanying Public Law 98–21, March 1983.

Regardless, there has been downward pressure on both DME and IME reimbursement from the federal government in recent years, and while there are calls from some in Congress to stop or even reverse this trend, the federal deficit is likely to continue to exert financial pressure on the Medicare program.

B. GME Reimbursement for New Teaching Hospitals

BBA was the specific legislation that capped the number of resident FTEs a teaching hospital could claim for reimbursement on its Medicare cost report at the hospital's unweighted FTE count for the most recent cost reporting period ending on or before December 31, 1996. For hospitals that did not offer GME programs at the time of the cap, CMS established the following exception:

“If a hospital had no residents before January 1, 1995, and it establishes one or more new medical residency training programs on or after that date, the hospital's FTE cap will be based on the number of first-year residents participating in its accredited graduate medical education training programs in the third year of receiving payment for direct GME. The hospital's unweighted FTE resident cap will equal the product of the number of first-year residents in that year, and the number of years in which residents are expected to complete that program based on the minimum accredited length for the type of program, as published in the Graduate Medical Education Directory.”⁸

The above exception would appear to apply to the three hospitals and creates a financial incentive for rapid GME program growth. However, the imperatives for rapid growth will be challenged by the ability to successfully recruit high-quality residents into new programs. Importantly, any GME program growth in the future beyond the 3-year period (i.e., increase in residents in existing programs or the addition of new programs) will be ineligible for reimbursement. As detailed business planning efforts for new GME programs in Georgia commence, it is therefore of the utmost importance to develop strategies that maximize resident enrollment during the first 3 years of operation while balancing the need to provide clinical and didactic education at the highest levels of quality.

C. State Funding of GME in Georgia⁹

DME and IME reimbursement from Medicare often represents the only direct source of financial support for GME programs. However, in some states, the Medicaid program may also provide IME and/or DME reimbursement to teaching hospitals. In states where such reimbursement is available, the magnitude of the Medicaid payments generally pale in comparison to the Medicare payments.

The Georgia state legislature created a commission in the late 1990s to explore options for creating a statewide GME trust fund to support ongoing medical education in Georgia. This activity was

⁸ *Federal Register*, Vol. 62, No. 168, Section 413.86(g).

⁹ *State and Managed Care Support in Graduate Medical Education: Innovations and Implications for Federal Policy*. Council on Graduate Medical Education (COGME) Resource Paper, July 2004.

motivated in part by a concurrent decline in federal funding for Georgia Area Health Education Centers (AHECs) and the rural GME programs associated with them.

Georgia's Medicaid program paid a lump sum to MCG through a line-item appropriation beginning in 2000 in order to support core clinical training efforts in all state AHECs. This funding was disbursed through the state university's resident instruction budget via a designated account to support the AHECs. A temporary transfer of funds by the university back to Medicaid enabled Medicaid to access additional federal matching funds to support benefits for Medicaid patients in rural and medically underserved communities. Reportedly, Georgia enjoyed a 1:1 match of state and federal Medicaid dollars, totaling approximately \$1.45 million in aggregate. In 2003, the state contributed an incremental \$300,000 to support initiatives including a new AHEC and the training of additional students in medicine, physician assistant (PA), nurse practitioner (NP), and other health professional training programs. This led to total funding in that year of approximately \$1.8 million.

A 2005 AAMC survey indicated that in the United States, 46 states (including Georgia) and the District of Columbia made both DME and IME payments under their Medicaid fee-for-service (FFS) programs. Fourteen states (excluding Georgia) and the District of Columbia made DME and IME payments explicitly and directly to teaching hospitals under capitated managed care programs – a decline from 17 states doing so in 2002. In 2005, Georgia reported making \$76.2 million in Medicaid DME payments.¹⁰

In addition, in 2006 the Georgia Statewide AHEC Network received approximately \$3.5 million in state, federal, and local funding to support the needs of students engaged in and/or considering training in the health professions. The state portion of this funding totaled just over \$1.4 million, of which approximately 93 percent originated with the Department of Community Health (DCH).¹¹ However, it is important to note that this funding supports not only the expenses associated with GME, but also those of undergraduate medical students and students in myriad other health professional training programs.

Until May 2006, all Georgia Medicaid payments for GME were included in each hospital's FFS inpatient case rate. Later in 2006, over 1 million families were transitioned from traditional Medicaid FFS plans to care management organizations (CMOs). While DCH continued to pay the GME payment per case rate for FFS claims submitted during and after this transition, it is expected that FFS claims will decline precipitously over time.¹²

¹⁰ *Financing Graduate Medical Education: Some Basics*. Presentation by Ms. Karen Fisher of AAMC to Georgia House of Representatives Medical Education Study Committee. August 15, 2007.

¹¹ *Annual Report of the Area Health Education Centers Program*. Georgia Statewide AHEC Network.

¹² *Care Management Organization: GME Supplemental Payment*. Georgia DCH/Georgia Healthy Families, May 4, 2006.

VI. Proposed Collaborative Model for GME in Northeast Georgia

VI. Proposed Collaborative Model for GME in Northeast Georgia

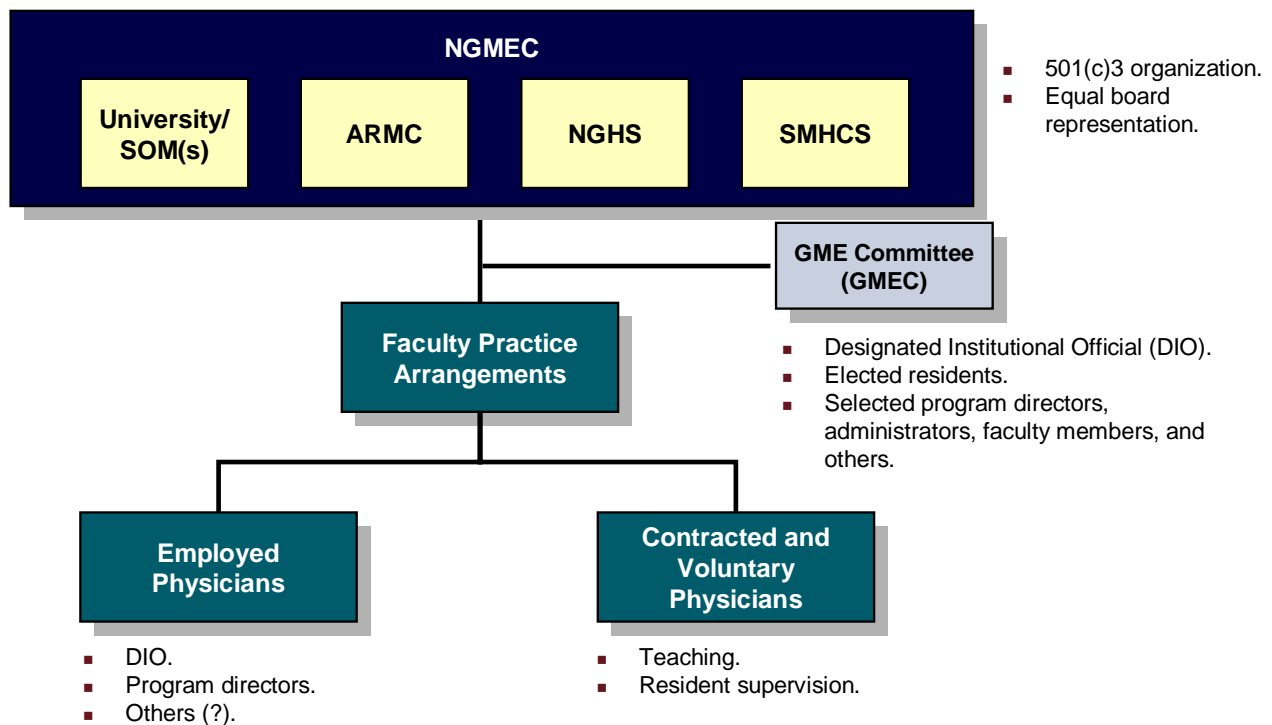
The optimal structure for achieving the goals and objectives for increasing the Georgia physician workforce is a medical education consortium, typically defined as an organization or arrangement developed to unite the diverse group of stakeholders necessary to reorganize and/or effectively manage medical education. Medical education consortia include two or more separate institutions involved with GME and are formed to reorganize and/or strengthen medical education through shared and joint decision making.

Member organizations of medical education consortia typically report many benefits to their medical education enterprises, including:¹³

- Furthering and protecting the interests of community physicians by providing a forum for addressing workforce and other concerns.
- Improving working relations and dispute resolution by bringing hospital executives, medical school deans, and academic department chairs and clinical service chiefs together on a regular basis.
- Enhancing administrative efficiency by coordinating the oversight of educational quality, program requirements, and accreditation, and by sharing the administrative costs of GME to reduce redundancies and realize economies of scale.
- Coordinating programs' financial arrangements by providing transparency of the sources and uses of education funds, defining equitable resource distributions and contributions, and enabling a longer financial planning horizon through pre-set financial support commitments.

After examining the attributes and performance characteristics of GME consortia models nationally, the steering committee developed a conceptual framework for applying a consortium model to the hospitals as a vehicle for GME program development and operation, illustrating it as NGMEC. NGMEC is envisioned as an incorporated, tax-exempt, 501(c)3 organization, with member organizations including the hospitals and appropriate academic partners (i.e., university and/or schools of medicine [SOMs]).

¹³ Data regarding consortia derive from proprietary ECG surveys and engagements, and from *Graduate Medical Education Consortia: A National Survey*, published in 1996 by AAMC and the Center for Health Professions (CHP) at University of California, San Francisco (UCSF).



The current conceptual framework identifies that once incorporated, NGMEC will seek accreditation as the institutional sponsor of the GME programs.

NGMEC will focus on achieving multiple vital objectives for the state and region, and for its member organizations, which closely reflect the benefits of national consortia models cited above. Specific shared objectives identified by the GME steering committee include:

- Training excellent physicians to practice in Georgia, and particularly in northeast Georgia.
- Providing opportunities to integrate undergraduate medical education (UME) clerkships and GME.
- Ensuring high quality by providing streamlined, efficient oversight of multiple GME programs.
- Contributing to patient care quality.
- Fostering a learning environment across all care sites.

Strong governance is a critical success factor for medical education consortia. Accordingly, NGMEC must define a board of directors, which provides balanced representation for all member organizations, in its corporate bylaws. It is advisable for each organization to include the CEO (or his/her designee), plus a board member/trustee, so that the governing bodies of the various constituent entities remain apprised of current academic medical center (AMC) issues. These governance constructs will not only foster open discussion and a spirit of coordination and collaboration, but also engage senior management and board members in the mission, goals, and challenges of NGMEC.

The shared governance structure should set strategy and policy for the educational enterprise, approve academic budgets, and oversee educational operations. The NGMEC bylaws should specify the governing board's authorities and provide a mechanism for the member organizations to address important considerations. Typical areas addressed by consortium bylaws include:

- Clinical education and affiliation arrangements.
- Arrays of teaching affiliates and program assignments.
- Coordination of the academic budget and designation of the flow of funds.
- Hiring authority for, and locations of, department chairs.
- The roles of full-time faculty and community physicians.
- Coordination of educational administration.

The hospitals have discussed offering a suite of GME programs that would address specific needs within the state and region and serve as core components of a robust GME enterprise. While the composition of the enterprise was not finalized, the preliminary programs and potential sizes discussed include:

GME Program	Minimum Program Size
Emergency Medicine	<ul style="list-style-type: none"> ■ 24 residents total. ■ 6 residents per training year.
Family Medicine	<ul style="list-style-type: none"> ■ 12 residents total. ■ 4 residents per training year.
Internal Medicine	<ul style="list-style-type: none"> ■ 12 residents total. ■ 4 residents per training year.
OB/GYN	<ul style="list-style-type: none"> ■ 8 residents total. ■ 2 residents per training year.
Pediatrics	<ul style="list-style-type: none"> ■ 12 residents total. ■ 4 residents per training year.
Psychiatry	<ul style="list-style-type: none"> ■ 12 residents total. ■ 3 residents per training year.
Surgery	<ul style="list-style-type: none"> ■ 10 residents total. ■ 2 residents per training year.
Transitional Year	<ul style="list-style-type: none"> ■ 4 residents total.

GME programs will be overseen by a centralized GMEC, which will address issues of program siting and resident rotations according to each organization's available resources, preferences, and

other factors. ACGME requirements stipulate that GMEC membership must include the DIO,¹⁴ residents nominated by their peers, representative program directors, administrators, faculty members, and others as determined. The GMEC and DIO are jointly responsible for ensuring compliance with ACGME institutional and program-specific requirements.

NGMEC employees (or leased staff) will include:

- GME administrative staff, including program coordinators and secretarial/clerical staff.
- GME program directors (for their protected nonclinical time devoted to program oversight).
- DIO.
- Faculty physicians (for the percentage of time devoted to teaching and other GME-related activities).¹⁵
- Residents and fellows.

NGMEC will have a shared funding model. Core consortium and administrative costs will be shared equally, while other expenses will be allocated to members based on the number of residents and fellows assigned to their institutions. Any Medicare or Medicaid reimbursement for GME will accrue directly to the recipient institution. Whenever possible, other funds (e.g., state appropriations for GME) will accrue directly to the consortium.

¹⁴ A DIO is required by ACGME to be appointed by each institution to supervise high-level accreditation and program issues. The DIO is generally a physician or administrator devoting a percentage FTE to these duties.

¹⁵ Selected faculty will be employed by or through the consortium, and others may be under contract.

Appendix A

Appendix B