Rural Graduate Medical Education Opportunities for States

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NORTH CAROLINA AHEC
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Disclosures

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The content are those of the presenters and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

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Objectives

1. Understand characteristics of prime rural hospitals for GME development with regard to volume/clinical mix, financial status, and geography.
2. Recognize hospital and community characteristics associated with categories.
3. Understand factors associated with hospital categories.
4. Discuss program development considerations and resources to support GME development.

HRSA's Investment in Program Development

- HRSA's Rural Residency Planning and Development (RRPD) program has awarded **$54M** to **73 organizations** across **36 states and six medicine disciplines**.[2]
- HRSA's Teaching Health Center Planning and Development (THCPD) program has awarded **$46.27M** to **93 organizations** across **36 states** and **eight medical and dental specialties**.
- HRSA has funded Technical Assistance Centers to support development of new residencies via consultations, advising, education, and community learning.

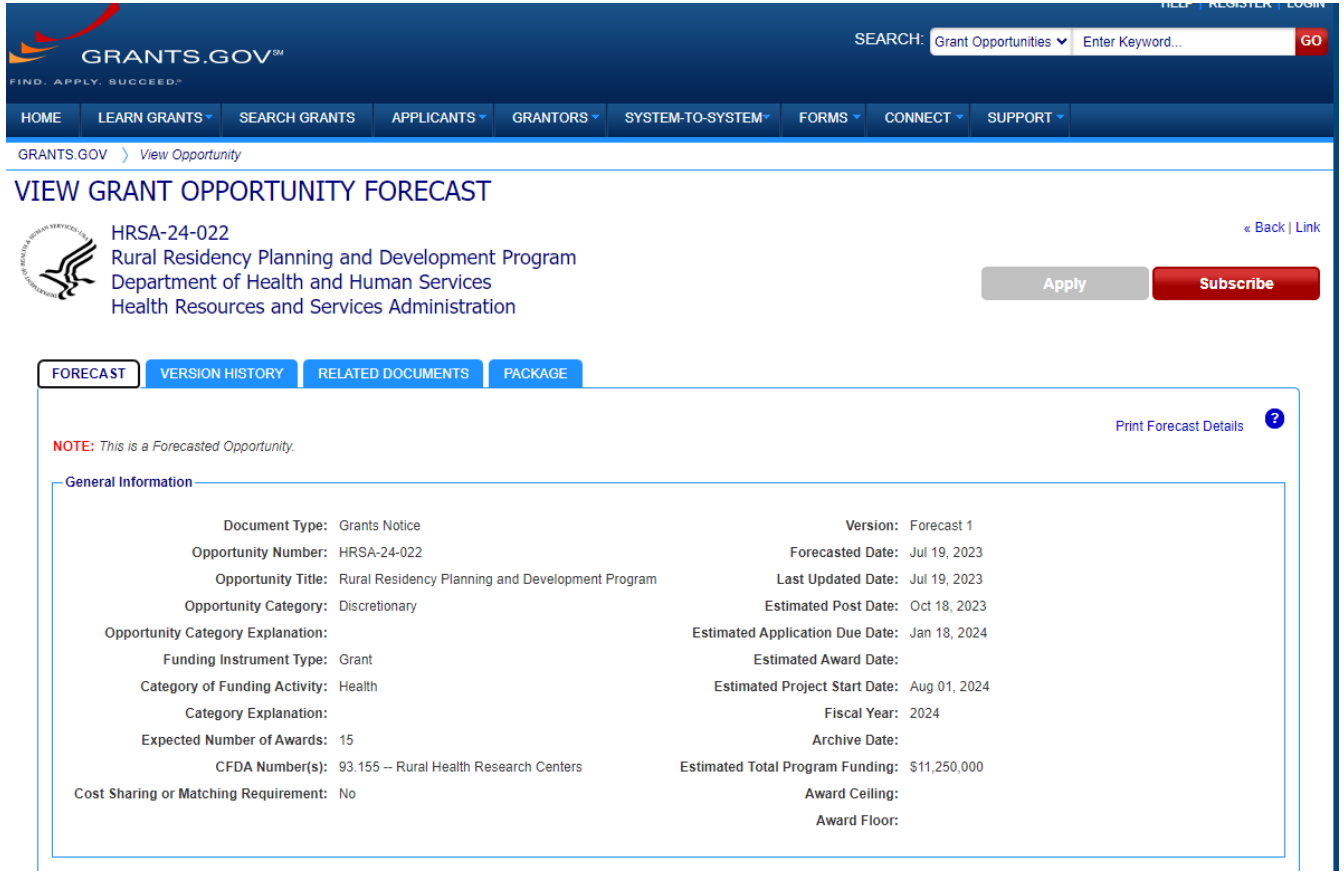
1. US Government Accounting Office. https://www.gao.gov/products/gao-21-329
2. https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd

Map: https://www.ruralgme.org/

RRPD Outcomes To Date

- Created **39 new accredited rural residencies** in family medicine, internal medicine, psychiatry, and general surgery
- Received ACGME approval for **515 new residency positions in rural areas**
- 31 programs **matched with 308 residents** for training in rural areas
- 22 programs are training **184 resident physicians** in rural clinical settings

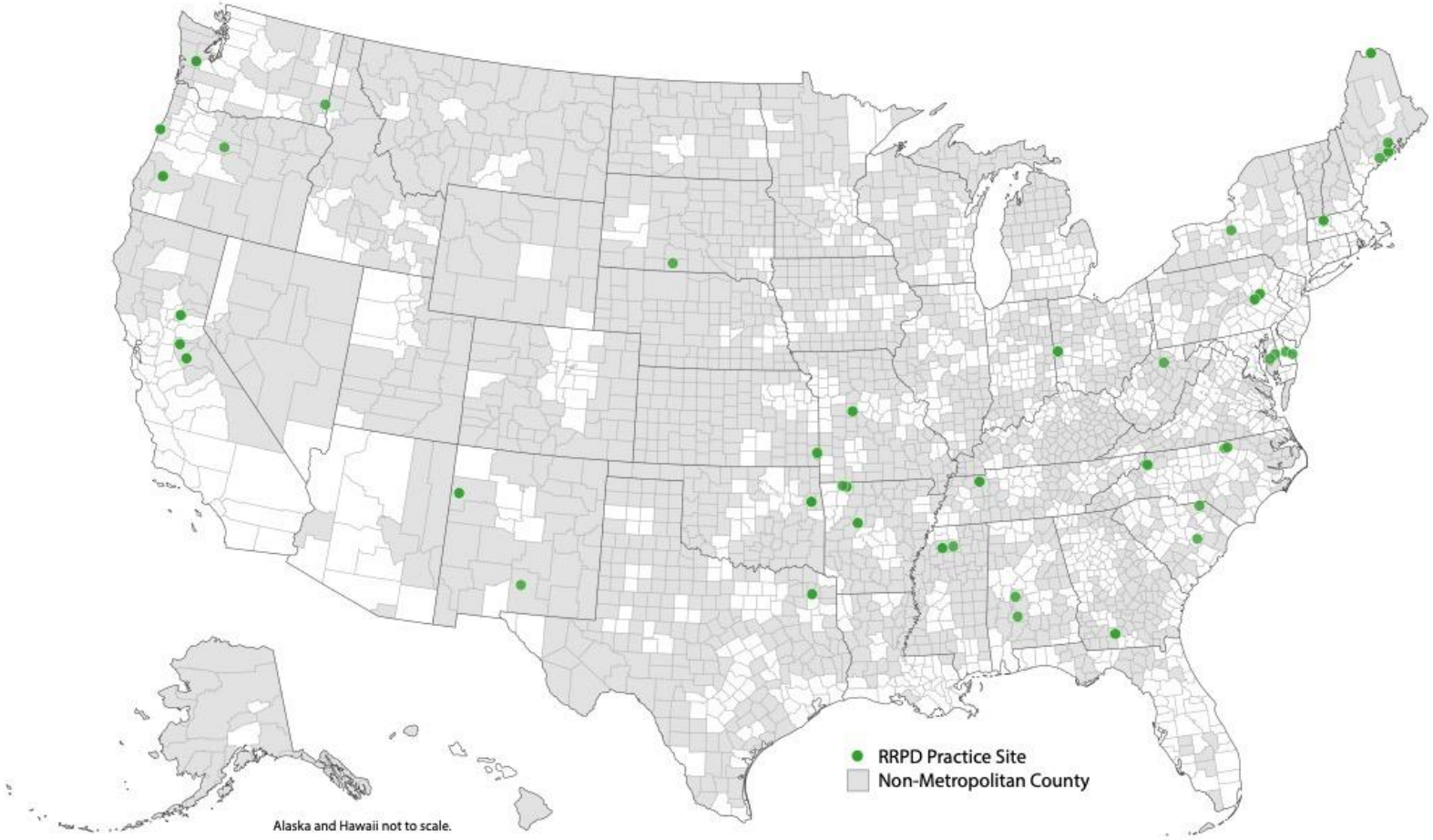
RRPD – Cohort 6 Notice of Funding



Available at https://www.grants.gov/web/grants/view-opportunity.html?oppId=349410

RRPD Training Site Analysis

We conducted a bivariate analysis comparing the community characteristics of the 40 counties with RRPD programs to the 1,932 non-metropolitan counties in the US that do not currently have an RRPD program.



J Rural Health. 2023 Jun;39(3):521-528. doi: 10.1111/jrh.12735.

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Population Characteristics

Population Characteristic	Non-Metro Counties with an RRPD Program	Non-Metro Counties without an RRPD Program
Average Population (2017)**	53,767 (9,339-225,322)	22,674 (88-200,381)
Population Density/Sq. mile (2010)*	73 (6.9-211)	43 (0-2,820)
% Non-white or Hispanic (2017)*	30% (4-92%)	22% (2-97%)
% 65 & over (2017)	20% (7-28%)	20% (6-40%)

* p<.05; **p<.01

Income Characteristics

Income Characteristic	Non-Metro Counties with an RRPD Program	Non-Metro Counties without an RRPD Program
Median Income (2013-2017)	$44,484 ($22,973-$65,595)	$45,500 ($13,462-$110,190)
Persistent Poverty (% of counties) (2014)	20%	15%
% of population in poverty (2017)*	19% (9-50%)	17% (4-57%)
Medicaid Eligible*	28% (9-61%)	25% (3-67%)

* p<.05; **p<.01

Provider Facility Characteristics

Provider Facility Characteristic	Non-Metro Counties with an RRPD Program	Non-Metro Counties without an RRPD Program
% of counties w/no hospital (2010)*	8%	23%
Average Hospital Bed Size (2017)**	141 (25-524)	79 (2-1,064)
Primary Care Physicians per 10K pop (2017)**	6.0 (2.0-11.5)	4.7 (0-43)

* p<.05; **p<.01

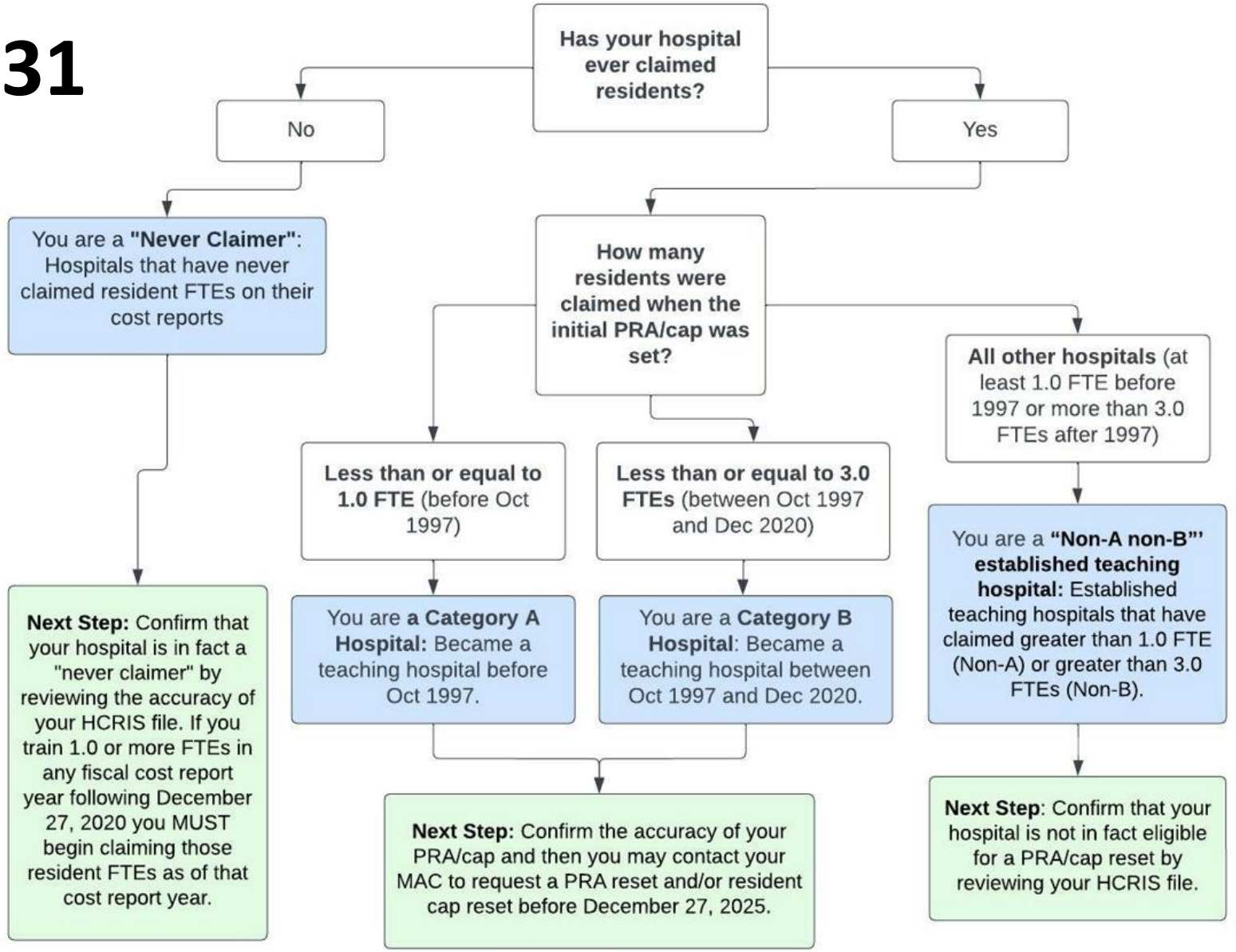
County Analysis Results

- Both **higher population** ($p<0.001$) and **PCP ratio** ($p=0.046$) were **strong predictors** while the social vulnerability index ($p=0.07$) was a weak predictor of being a RRPD county
- **Large enough infrastructure:** RRPD counties have the population and existing physician supply to support a training program
- **Socioeconomic need:** RRPD counties are more socially vulnerable
- Counties with an **SVI of 1.0, 10 PCPs per 10K population, 98 thousand population**, and contiguous to a metro county had the profile most similar to RRPD sites.

Funding Challenges in Growing Rural GME

- CMS has reimbursement rules that have historically disadvantaged hospitals from starting or expanding residency training in many rural settings.
  - The cap has hindered rural hospitals from increasing training slots.
  - Resident rotators at rural hospitals have triggered low per resident amounts (PRAs)
- To address this problem, CMS recently executed regulations as a result of Section 131 of the Consolidation Appropriations Act (CAA).
  - Allows resetting of the PRA for some hospitals that have a low or zero PRA
  - Permits certain hospitals to add cap positions for a new residency program that has historically had low full time equivalent (FTE) caps.

Section 131



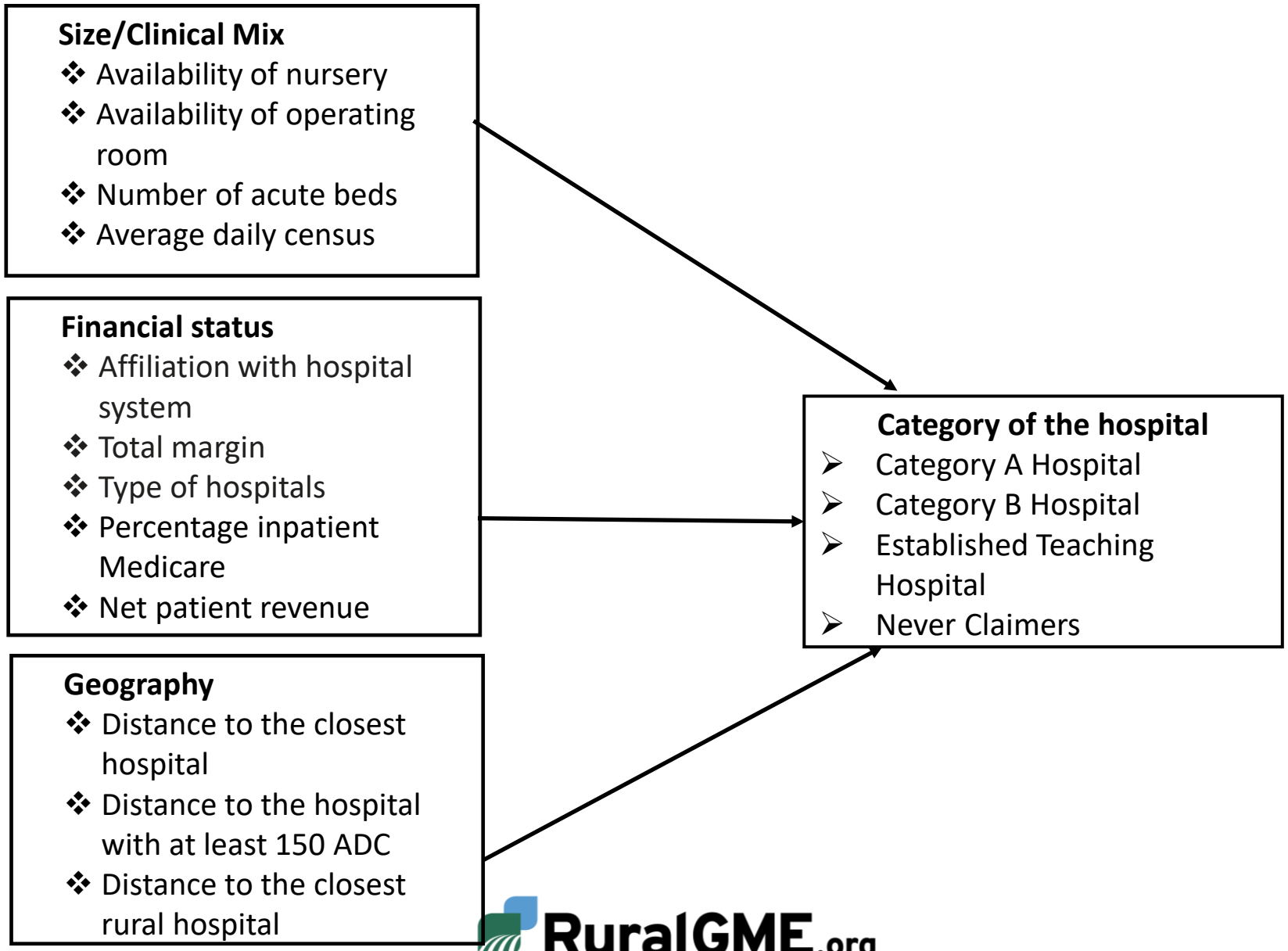
Academic Medicine97(9):1259-1263, September 2022.
doi: 10.1097/ACM.0000000000004797

Research Aims

- To describe the characteristics of the hospitals categorized under Section 131 and the communities they serve.

- To identify the rural Never Claimers that are most similar to teaching hospitals to determine those that may be good candidates to sponsor GME programs.

Conceptual Framework



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Methods

- **Data sources:**
  - March 2022 Medicare Cost report Data (HCRIS data)
  - 2022 County Health Rankings and Roadmaps data
- **Analysis:**
  - Bivariate association using Chi-square and Mann-Whitney tests
  - Multivariate associations using multinomial logistic regressions.

Methods

- Labor and delivery and surgical services were defined by having at least $10,000 in charges for that service (using nursery for labor and delivery).
- Based on payment mechanisms, we excluded Critical Access Hospitals (CAH) and classified each hospital into one of three categories:
  1) Prospective Payment System (PPS) Hospital
  2) Rural Referral Centers (RRC) and/or Sole Community Hospital (SCH)
  3) other hospital payment types including Medicare Dependent Hospitals, Indian Health Service, and Cancer hospitals
- Rurality was defined based on Rural-Urban Commuting Area Codes (RUCA) Codes (≥4 is rural).

Results: Hospital Characteristics

		Total sample	Category A	Category B	ETH	Never Claimer
		N=3590	N=56	N=312	N=1147	N=2,115
Rurality (RUCA)	Rural	1,130 (31.5%)	9 (16.1%)*	71 (22.8%)*	91 (7.9%)*	959 (46.2%)
	Urban	2,460 (68.5%)	47 (83.9%)	241 (77.2%)	1,056(92.1%)	1,116 (53.8%)
Nursery	No	1,306 (36.5%)	18 (32.1%)	76 (24.4%)	278 (24.2%)	934 (45.2%)
	Yes	2,275 (63.5%)	38 (67.9%)	236 (75.6%)*	869 (75.8%)*	1,132 (54.8%)
Operating Room (OR)	No	159 (4.4%)	0 (0.0%)	4 (1.3%)	13 (1.1%)	142 (6.9%)
	Yes	3,422 (95.6%)	56 (100.0%)	308 (98.7%)*	1,134 (98.9%)*	1,924 (93.1%)
Hospital System	No	1,157 (32.2%)	8 (14.3%)	61 (19.6%)	304 (26.5%)	784 (37.8%)
	Yes	2,433 (67.8%)	48 (85.7%)*	251 (80.4%)*	843 (73.5%)*	1,291 (62.2%)

*P-value < 0.05; referent is Never Claimer

Results: Hospital Characteristics

		Total sample	Category A	Category B	ETH	Never Claimer
		N=3590	N=56	N=312	N=1147	N=2,115
Hospital Type	**PPS**	2,264 (63.1%)	37 (66.1%)	215 (68.9%)*	729 (63.6%)*	1,283 (61.8%)
	RRC &/or SCH	1,092 (30.4%)	18 (32.1%)	91 (29.2%)	397 (34.6%)	586 (28.2%)
	Other	234 (6.5%)	1 (1.8%)	6 (1.9%)	21 (1.8%)	206 (9.9%)
Net Patient Revenue (million)		145.5 (53.8-346.4)	292.4* (142.8-512.1)	212.5* (111.2-373.8)	393.7* (204.0-735.1)	78.9 (31.5-162.7)
Total Margin (%)		7.4 (0.2-15.4)	7.8 (3.8-17.5)	9.6* (2.4-19.6)	7.1 (1.0-14.2)	7.1 (-0.9-15.7)
Percent Inpatient Medicare		32.2 (24.4-41.2)	31.7 (25.1-41.5)	30.4* (24.1-37.8)	28.1* (21.5-35.2)	35.5 (26.9-45.1)

*P-value < 0.05; referent is Never Claimer

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Results: Hospital Characteristics

	Total sample	Category A	Category B	ETH	Never Claimer
Number of Acute Beds	120 (49-248)	208* (122-294)	148* (91-256)	273* (163-431)	66 (37-130)
Acute Average Daily Census (ADC)	56.6 (14.8-147.2)	108.7* (53.5-173.5)	86.0* (42.1-152.0)	165.3* (88.2-300.0)	23.4 (8.0-62.1)
Miles to any Closest Hospital	5.2 (1.9-14.3)	4.1* (1.2-9.9)	5.2* (2.5-13.2)	2.4* (1.1-5.1)	9.9 (3.4-17.7)
Miles to any Closest Hospital with at least 150 ADC	12.2 (3.9-34.1)	5.9* (3.2-38.8)	11.7* (5.0-27.4)	4.6* (1.7-14.4)	22.6 (7.9-42.4)
Miles to the Nearest RRC	22.0 (7.6-39.2)	14.4* (4.8-40.3)	18.6* (9.7-34.8)	11.7* (3.6-34.4)	25.9 (13.6-42.2)

*P-value < 0.05; referent is Never Claimer

Results: Hospital Characteristics

- The ETHs had the highest net patient revenue while the Never Claimer hospitals had the lowest.
- The Category B hospitals had the highest median total margin (9.6%) while the ETH and Never Claimers had the lowest (7.1%).
- The median (aerial) distance from Never Claimer hospitals to any **closest hospital** was **about 10 miles**, and to the nearest hospital with at least **150 ADC was 22.6 miles**.
- The median (aerial) distance from ETHs to any **closest hospital** was **about 2.4 miles**, and to the nearest hospital with at least **150 ADC was 4.6 miles**.
- Out of 1515 GME hospitals, **11.3% were located in rural areas**.

Factors Associated with Hospital Categories

- **Category A predictors** = higher NPR, affiliation with the hospital system, and less mileage to the closest RRC.
- **Category B predictors** = higher NPR, lower percent inpatient Medicare, and higher acute ADC
- **Established Teaching Hospital predictors** = higher NPR, lower total margin, lower percent inpatient Medicare, higher acute ADC, less mileage to closest hospitals
- **Net patient revenue** was the strongest predictor of being a GME hospital.
- Rurality was not a factor in determining the GME category after adjusting for other hospital characteristics.

Community served by hospital categories

- The Never Claimer hospitals served an **older population, those with a higher age-adjusted death rate and greater proportion of non-Hispanic population** compared to all other categories.
- The Never Claimer hospitals cared for a greater proportion of **uninsured adults** compared to Category B (13.1 vs 11.9) and ETHs 13.1 vs 10.7), and **uninsured children** compared to all other categories.
- The Never Claimer hospitals are located in communities with **lower availability of primary care physicians, dentists, and mental health providers.**

Results: Community Characteristics

	Category A	Category B	ETH	Never Claimer
	N=73	N=379	N=1,391	N=3,581
Poverty percent, all ages	12.3 (9.4-14.6)	12.4 (9.0-15.1)	12.8 (9.8-15.3)	12.5 (9.6-15.7)
Non-Hispanic Black (percent)	6.2 (2.8-18.6)*	7.5 (2.2-15.3)*	11.5 (5.5-23.0)*	3.1 (0.9-10.4)
Hispanic (percent)	12.8 (6.4-26.0)*	10.1 (4.3-25.6)*	11.0 (5.6-25.6)*	6.1 (3.0-15.9)
Non-Hispanic White (percent)	60.1 (41.8-79.7)*	64.8 (44.4-83.3)*	58.6 (41.7-74.5)*	77.8 (57.0-90.1)
Age 65 and over (percent)	15.9 (14.4-18.2)*	17.1 (14.9-19.6)*	16.2 (14.5-18.3)*	19.0 (15.9-21.9)
Less than 18 years (percent)	21.6 (20.3-23.4)	22.2 (20.5-23.8)	21.4 (20.3-23.2)*	22.1 (20.3-24.1)
Uninsured adults (percent)	11.8 (8.8-15.0)	11.9 (8.8-16.1)*	10.7 (7.9-14.4)*	13.1 (9.1-18.0)
Uninsured children (percent)	4.2 (3.4-6.5)*	4.5 (3.5-6.8)*	4.1 (3.0-5.8)*	5.6 (3.9-8.3)

*P-value < 0.05; referent is Never Claimer

Results: Community Characteristics

	Category A	Category B	ETH	Never Claimer
Fair or poor health (percent)	19.1 (16.4-20.6)	19.7 (16.4-22.0)	19.2* (16.2-21.7)	19.7 (16.5-23.5)
Preventable hospitalization rate	3727.0 (2800.0-4520.5)	3825.0 (3112.0-4472.0)	4002.0 (3257.0-4626.0)	3882.0 (2980.0-4703.0)
Age-adjusted death rate	351.1* (288.9-436.7)	358.4* (291.2-436.5)	362.6* (294.2-431.3)	394.5 (327.5-489.8)
Primary care physician rate	84.2* (70.3-97.3)	73.2* (53.1-87.2)	87.4* (70.7-110.8)	55.7 (39.0-78.1)
Mental health provider rate	310.9* (222.6-440.0)	238.5* (163.9-375.0)	315.0* (209.6-408.1)	160.7 (81.3-278.6)
Dentist rate	82.9* (67.9-92.1)	68.0* (49.8-87.1)	78.0* (65.9-93.5)	52.0 (34.2-70.8)

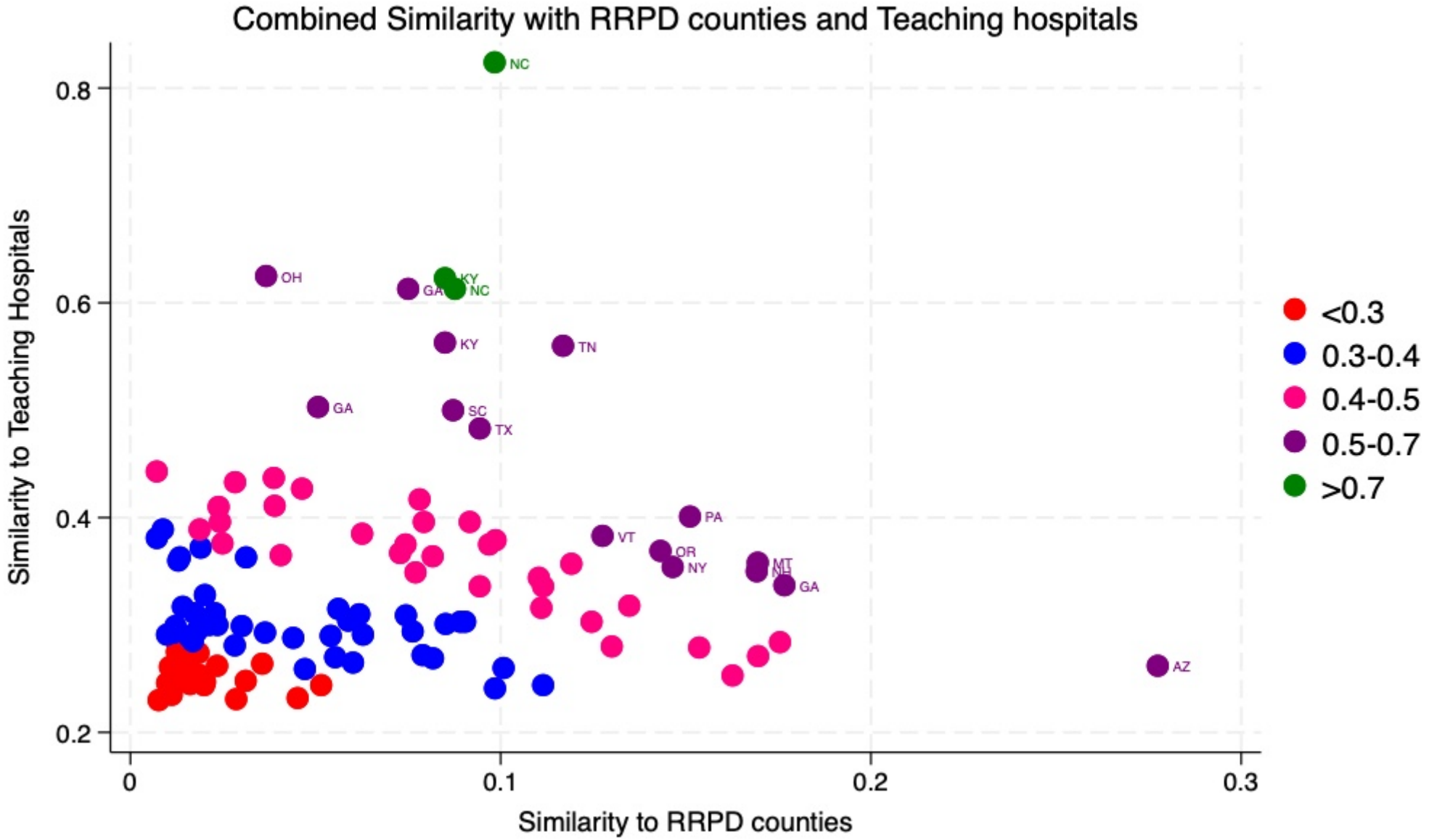
*P-value < 0.05; referent is Never Claimer

Policy implications

- To identify rural Never Claimers who may be good candidates for launch new rural GME programs, we calculated the probability of each rural hospital being in each of the four categories.
- There are roughly 145 rural Never Claimers that could consider sponsoring a potential rural residency program (6 Category A, 64 ETH, 75 Category B).

Top ten Never Claimer Rural Hospitals with Highest Probability for New GME Funding

Rank	Census region	RUCA	Average Daily Census (ADC)	Hospital System affiliation	Net patient revenue (million)	Total margin (percent)	Miles to nearest hospital with at least 150 ADC
1	South	4	283	Yes	777.6	20.26	32.1
2	Midwest	4	135	Yes	513.7	15.1	43.8
3	South	4	99.9	Yes	342.7	8.7	85.3
4	South	4	125.0	No	363.4	10.8	22.6
5	South	4	173.2	Yes	326.6	23.3	39.2
6	South	4	108.1	Yes	283.1	20.7	87.1
7	South	4	180.8	No	326.3	1.73	55.2
8	South	4	117.3	No	441.2	9.8	110.9
9	Midwest	4	99.2	Yes	458.6	5.6	33.1
10	South	4	123.7	Yes	286.2	27.3	29.2



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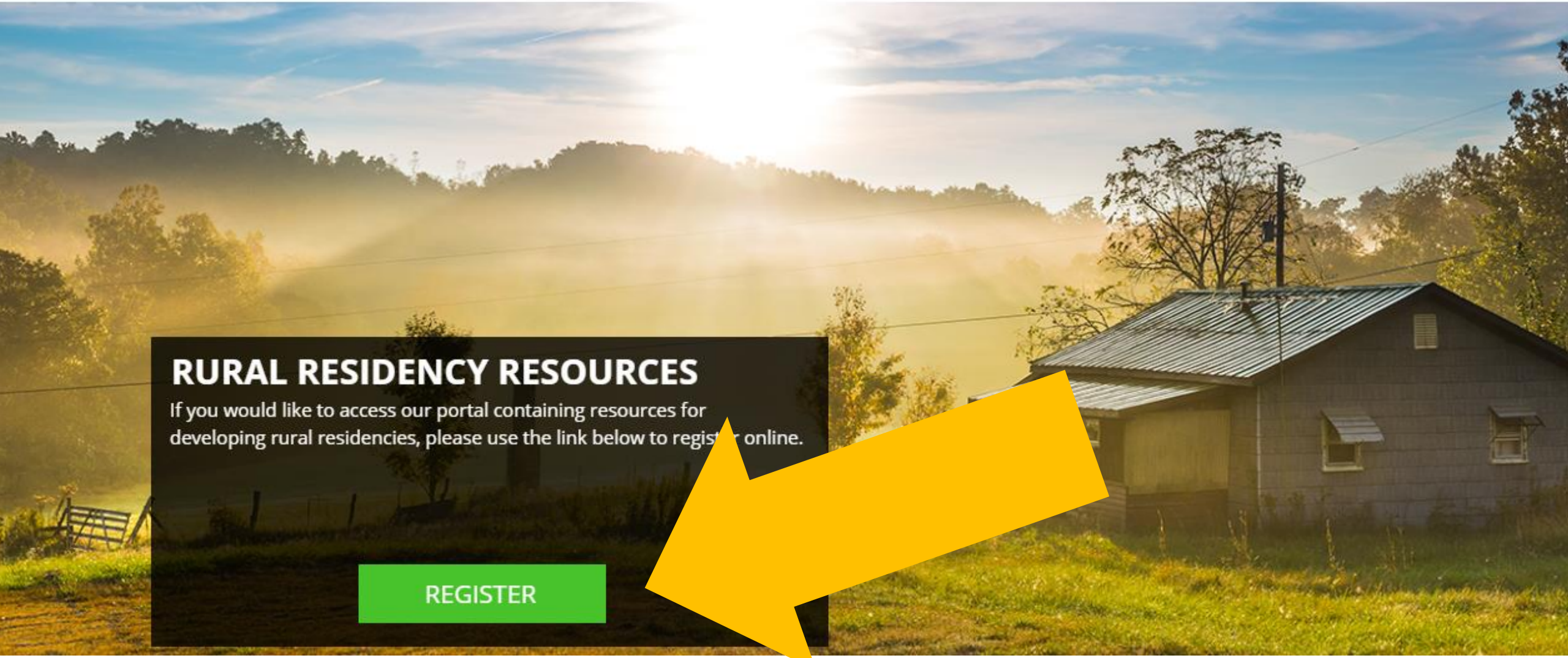

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Prime Rural Hospitals for GME Development

RuralGME.org

Get Started

Click here to view the recommended timeline for starting your residency program by 2022.

Toolbox

Click here to view tools and resources to help with planning and developing your residency program.

Program(s)

Click here to view details regarding your program, including the Progress Tracker and Assessments.

Financial Planning | Specialty: Not Specialty Specific | Type: Article Or White Paper

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PRIME Hospitals for GME Training

This data file provides a high-level overview of rurally located hospitals that are not currently training medical residents and may be prime candidates for launching a rural graduate medical education (GME) program.

Prime Rural Hospital File

Hospital Candidates for New Rural Residency Programs Under CAA Sec. 131

This data file provides a high-level overview of rurally located hospitals that are not currently training medical residents and may be prime candidates for launching a rural graduate medical education (GME)

Using Medicare Cost Report data, the Rural Residency Planning and Development Technical Assistance Center found that **these rural hospitals have characteristics similar to teaching hospitals**. Hospitals are urged to carefully review these data and confirm details and eligibility to launch new graduate medical education programs.

Under Sec. 131 of the Consolidated Appropriations Act, these hospitals can start residency programs and receive both Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments upon launching a residency program. Free resources are available on ruralgme.org to support the launch of rural residency programs, and you can reach out to the RRPD-TAC by emailing info@ruralgme.org.

For more detail on the opportunity to launch new rural residency programs, visit https://portal.ruralgme.org/

To learn more about the characteristics of a particular hospital, visit https://portal.ruralgme.org/hospital-analyzer

Provider Number	Name	Address	City	County	State	Zip	Acute average daily census	Hospital System Affiliation (Yes=1, No=0)	Net patient revenue (millions)	Total margin	nearest hospital with at least 150 Average daily census
340115	FIRSTHEALTH MOORE REGIONAL HOSPITAL	35 MEMORIAL DRIVE	PINEHURST	MOORE	NC	28374-	282.7315068	1	777.6312	0.202658602	32.12515
360039	GENESIS HEALTHCARE SYSTEM	2951 MAPLE AVENUE	ZANESVILLE	MUSKINGUM	OH	43701	134.5753425	1	513.7749	0.151218297	43.8632
180104	BAPTIST HEALTH PADUCAH	2501 KENTUCKY AVENUE	PADUCAH		KY	42003-	99.87123288	1	342.6781	0.086816753	85.36261
340021	ATRIUM HEALTH CLEVELAND	201 EAST GROVER STREET	SHELBY	CLEVELAND	NC	28150	173.1506849	1	326.5622	0.233103173	22.66641
110095	TIFT REGIONAL MEDICAL CENTER	901 EAST 18TH STREET	TIFTON	TIFT	GA	31793-	125.0273973	0	363.4008	0.107755445	39.23814
180102	MERCY HEALTH LOURDES HOSPITAL LLC	1530 LONE OAK ROAD	PADUCAH	MC CRACKEN	KY	42003	108.1205479	1	283.1109	0.206627294	87.15669
440059	COOKEVILLE REGIONAL MEDICAL CENTER	142 WEST FIFTH STREET	COOKEVILLE	PUTNAM	TN	38501	180.7945205	0	326.2704	0.017331487	55.1968
130002	ST LUKES MAGIC VALLEY REG MED CTR	801 POLE LINE ROAD WEST	TWIN FALLS	TWIN FALLS	ID	83301	99.21369863	1	458.6102	0.056429714	110.9282
80007	BEEBE MEDICAL CENTER	424 SAVANAH ROAD	LEWES	SUSSEX	DE	19958-	117.2547945	0	441.1819	0.097505368	33.19947
110038	JOHN D. ARCHBOLD MEMORIAL HOSPITAL	GORDON AVENUE AT MIMOSA DRIVE	THOMASVILLE	THOMAS	GA	31792-	123.7534247	1	286.196	0.273030731	29.28746
390168	BUTLER MEMORIAL HOSPITAL	ONE HOSPITAL WAY	BUTLER	BUTLER	PA	16001	132.2438356	0	268.3766	0.155042955	20.84454
420068	THE REGIONAL MEDICAL CENTER	3000 ST. MATTHEWS ROAD	ORANGEBURG	ORANGEBURG	SC	29115-	98.18082192	0	205.49	-0.071898621	37.65675
450211	CHI ST LUKES HEALTH MEMORIAL LUFKIN	1201 FRANK STREET	LUFKIN	ANGELINA	TX	75902-	75.66575342	1	152.1226	-0.022633379	76.27718
50013	ADVENTIST HEALTH ST. HELENA	10 WOODLAND ROAD	ST. HELENA	NAPA	CA	94574	57.22191781	1	225.2961	-0.030693372	14.04926
420067	BEAUFORT MEMORIAL HOSPITAL	955 S. RIBAUT ROAD	BEAUFORT	BEAUFORT	SC	29902-	86.76438356	0	261.2197	0.045954743	35.54348
110011	TANNER MEDICAL CENTER	705 DIXIE STREET	CARROLLTON	CARROLL	GA	30117-	143.7452055	0	290.1032	0.064720654	32.72105
50030	OROVILLE HOSPITAL	2767 OLIVE HIGHWAY	OROVILLE	BUTTE	CA	95965-	129.6438356	0	347.2743	0.039575468	23.1553
240043	MAYO CLNIC HLTH SYS-ALBRT LEA AUSTIN	1000 1ST DRIVE NW	AUSTIN	MOWER	MN	55912	41.00821918	1	276.6075	-0.031550505	51.09205

State Level Data

Provider Nu	Name	Address	City	County	State	Zip	average daily census	System Affiliation	revenue (millions)	Total margin	hospital with at least 150 Average daily census
340115	FIRSTHEALTH MOORE REGIONAL HOSPITAL	35 MEMORIAL DRIVE	PINEHURST	MOORE	NC	28374-	282.731507	1	777.6312	0.2026586	32.12515
340021	ATRIUM HEALTH CLEVELAND	201 EAST GROVER STREET	SHELBY	CLEVELAND	NC	28150	173.150685	1	326.5622	0.23310317	22.66641
340090	JOHNSTON HEALTH	509 NORTH BRIGHTLEAF BLVD	SMITHFIELD	JOHNSTON	NC	27577	113.290411	1	270.337	0.04965253	23.89634
340123	RANDOLPH HOSPITAL	373 NORTH FAYETTEVILLE STREET	ASHEBORO	RANDOLPH	NC	27204-	37.6520548	0	81.33557	-0.387131	20.53574
340008	SCOTLAND MEMORIAL HOSPITAL	500 LAUCHWOOD DRIVE	LAURINBURG	SCOTLAND	NC	28352-	69.4520548	1	188.6953	0.19009366	25.50233
340142	CARTERET COUNTY GENERAL HOSPITAL COM	3500 ARENDELL STREET	MOREHEAD CITY	CARTERET	NC	28557-	63.5041096	0	181.1393	0.14404646	31.9954
340126	WILSON MEDICAL CENTER	1705 SOUTH TARBORO STREET	WILSON	WILSON	NC	27893	74.4054795	1	134.5262	0.07734554	31.48389
340027	LENOIR MEMORIAL HOSPITAL	100 AIRPORT ROAD	KINSTON	LENOIR	NC	28501	72.4986301	1	114.2337	0.0187322	24.02213
340145	ATRIUM HEALTH LINCOLN	433 MCALISTER ROAD	LINCOLNTON	LINCOLN	NC	28092	64.8684932	1	176.4473	0.3454447	15.23676
340109	SENTARA ALBEMARLE REGL MED CTR LLC	1144 NORTH ROAD STREET	ELIZABETH CITY	PASQUOTANK	NC	27909	45.5027322	1	116.301	-0.0660893	29.34371

Rural Hospital Analyzer

RuralGME.org

State

NC

For more information on any thing listed in the report, please see the attached glossary.

City Clear

- AHOSKIE
- ALBEMARLE
- ASHEBORO
- ASHEVILLE
- BELHAVEN
- BLOWING ROCK
- BOONE
- BREVARD
- BRYSON CITY
- BURGAW
- BURLINGTON
- CARY
- CHAPEL HILL
- CHARLOTTE
- CHEROKEE
- CLINTON

Hospital	City	State	CCN
ALAMANCE REGIONAL MEDICAL CENTER	BURLINGTON	NC	340070
ALLEGHANY COUNTY MEMORIAL HOSPITAL	SPARTA	NC	341320
ANGEL MEDICAL CENTER	FRANKLIN	NC	341326
ASHE MEMORIAL HOSPITAL	JEFFERSON	NC	341325
ATRIUM HEALTH ANSON	WADESBORO	NC	340084
ATRIUM HEALTH CLEVELAND	SHELBY	NC	340021
ATRIUM HEALTH KINGS MOUNTAIN	KINGS MOUNTAIN	NC	340037
ATRIUM HEALTH LINCOLN	LINCOLNTON	NC	340145

FIRSTHEALTH MOORE REGIONAL HOSPITAL

(PINEHURST, NC: CCN 340115)

Produced: November 2022

This information sheet provides a high-level overview of various considerations for GME at this hospital. It is based on secondary information which may not be currently accurate. **Potential GME programs are urged to carefully review and confirm their current details and eligibility.** Additionally, developing rural programs should conduct an analysis of every potential training location for its curriculum using the Am I Rural? tool. Resources listed below provide additional information.

This hospital

- is located in a county designated as **Non-Metro** (defined by OMB's CBSA standards (2020)). For CMS Medicare GME purposes, only resident training in non-metro counties will count towards the requirement for RTP funding of at least 50 percent in non-metro counties.
- is classified as **Rural** by CMS. This may affect the hospital's ability to get new Medicare GME funding depending on its category described below.
- is considered **Rural** according to the Federal Office of Rural Health Policy (FORHP). Training in a FORHP-designated rural place will count towards the requirement for RRPD grant application of at least 50 percent in a "rural" place but won't count towards Medicare RTP funding requirements for rural training location unless the place is ***also*** not in a metro-CBSA.

A hospital may fall into multiple categories below - e.g. be both an RRC and a SCH or an Category A in a Lugar County.

Hospital in category?	**Category**	**Implications for GME.** Further details are provided in on the Rural GME Analyzer website.
	Critical Access Hospital (CAH)	NOT an IPPS hospital. Time residents spend in a CAH can be claimed by a residency partner IPPS hospital (if it meets nonprovider setting requirements) which often is more financially advantageous than direct expense claims by the CAH. The status of the partner IPPS hospital will matter when considering that option. Click for more detail.
	Sole Comunity Hospital (SCH)	A special type of IPPS hospital. Special rules apply that limit IME payments. Click for more detail.
	Medicare Dependent Hospital (MDH)	A special type of IPPS hospital. Special rules apply that limit IME payments. Click for more detail.
	Rural Comunity Hospital (RCH) Demonstration	A special type of IPPS hospital. Special rules apply that limit IME payments. Click for more detail.
Yes	Rural Referral Center (RRC)	A special type of IPPS hospital. Special rules apply that allow new GME programs to qualify for new Medicare GME payments. Click for more detail.
Yes	IPPS hospital that is a Never Claimer	There is no evidence this hospital ever claimed GME expenses on a Medicare cost report. Thus, this hospital is likely a GME-naïve hospital that can get Medicare GME payments when the hospital first starts resident rotations. Click for more detail.
	Category A	This IPPS Hospital has a low cap and may also have a low Per Resident Amount (PRA) suppressing their DGME payments. Category A and B hospitals may be able to reset their PRA and could add to that cap with a new GME program. Click for more detail.
	Category B	
	Established Teaching Hospital	This hospital has a cap high enough that it is not eligible for Category A or B reset opportunity. Their cap can't generally be increased unless it has a CMS classification and/or location or participates in a new RTP residency. Click for more detail.
	Indian Health Service (IHS) Hospital	Special considerations apply for IHS hospitals. Click for more detail.
	Lugar County	Hospitals in Lugar counties (all are classified as locations) have the option of reclassifying as to get a better wage rate. However, this can limit GME funding qualification. Click for more detail.

RuralGME

Glossary and CMS GME Funding System Background

Disclaimer:
All information provided below is based on the existing research and reports that our team has explored. This information is for general purposes only. We tried our best to provide the most updated information; however, there could be some discrepancies. Therefore, the users should refer to the specific resources/references if they want to explore more the specific terms.

IPPS hospitals
Most US acute care hospitals are Inpatient Prospective Payment System (IPPS) hospitals. IPPS hospitals are paid by Medicare for patient care using the Diagnosis Related Groups (DRG) system (see below), and can be geographically located in urban or rural areas. There are several Providers and units of hospitals that are excluded from the IPPS payment system, including: psychiatric hospitals; rehabilitative hospitals; Children's Hospitals, long term care hospitals; psychiatric and rehabilitation units of hospitals; cancer hospitals; critical access hospitals; and, VA and Indian Health Service Hospitals.

DRG payments
Diagnosis Related Group (DRG) payments are the means that Medicare uses to calculate payments to IPPS hospitals for each inpatient care stay for Medicare beneficiaries (Medicare part A). Each case is categorized into a diagnosis related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG in the country. There are local adjustments to the hospital's DRG payment based on local wage rates, cost of living, and for hospitals that serve a disproportionate share of low-income patients. Finally, for particular cases that are unusually costly, known as outlier cases, the IPPS payment is increased. For fee-for-service Medicare beneficiaries, the hospital is paid a final calculated DRG payment. For a patient admitted for the same diagnosis to that hospital the payment would be the same regardless of actual hospital costs or length of stay – exclusive of outliers. Medicare Advantage payments the hospitals are paid on a different basis as described below.

Next Steps in Working with Prime Rural Hospitals

- Investigate the Medicare GME situation (using the Hospital Analyzer) for all potential partner hospitals.
- Some hospitals may be better positioned to get new Medicare GME funding. The Hospital Analyzer Glossary provides on overview of this.
- If a hospital is category A or B they have until 12/27/25 to:
  - **apply for a PRA reset** once you start training and claiming >=1.0 (cat A) or >3.0 (cat B) FTE residents from **old or new** residencies in a year.
  - **apply for a CAP addition** once you start training and claiming >=1.0 (cat A) or >3.0 (cat B) FTE residents from **new** residencies in a year.
- Investigate Medicaid GME and other state level funding available

Additional Considerations

- The analysis shows a disproportionate distribution of hospital categories across rural and urban areas, with **net patient revenue** being the strongest predictor of GME status.
  - A hospital with less margin may be less likely to commit to the financial costs associated with developing a residency.
  - Other “predictors” speak to the **comprehensive nature of services** available at a hospital. Another factor in developing a residency **being “in a system”** – also potentially helpful for finances and GME expertise being available.

Additional Considerations

- Having said that… we see many rural communities with
  - **small often marginally profitable hospitals and clinical practices…**
  - **partnering with willing urban partners** to develop rural GME.
  - Smaller hospitals, like **CAHs,** establishing excellent programs.
- We also see **local, statewide and national stakeholders** willing to support these efforts financially.
  - the **RRPD and THCPD** grant programs
  - the enhancement of **Medicaid GME** in many states to support new rural program development, expansion, and technical assistance

Tools and Resources

Community Engagement

Program Design & Development

Financial Planning

Institutional Sponsorship

Program Accreditation

Program Implementation

STAGE 1 Exploration

Community Assets

Identify community assets and interested parties.

Leadership

Assemble local leadership and determine program mission.

Sponsorship

Identify an institutional affiliation or sponsorship. Begin to consider financial options and governance structure.

STAGE 2 Design

Initial Educational & Programmatic Design

Identify Program Director (permanent or in development). Consider community assets, educational vision, resources, and accreditation timeline.

Financial Planning

Develop a budget and secure funding. Consider development and sustainability with revenues and expenses.

Sponsoring Institution Application

Find a Designated Institutional Official and organize the GME Committee. Complete application.

STAGE 3 Development

Program Personnel

Appoint residency coordinator. Identify core faculty and other program staff.

Program Planning & Accreditation

Develop curricular plans, goals and objectives; evaluation system and tools; policies and procedures; program letters of agreement; faculty roster. Complete ACGME application and site visit.

STAGE 4 Start-Up

Marketing & Resident Recruitment

Create a website. Register with required systems. Market locally and nationally.

Program Infrastructure & Resources

Hire core faculty and other program staff. Ensure faculty development. Complete any construction and start-up purchases. Establish annual budget.

Matriculate

Welcome and orient new residents.

STAGE 5 Maintenance

Ongoing Efforts

Report annually to ACGME and the Sponsoring Institution. Maintain accreditation and financial solvency. Recruit and retain faculty. Track program educational and clinical outcomes. Ensure ongoing performance improvement.

To advance to the next stage: Make an organizational decision to proceed with investing significant resources in program development.

To advance to the next stage: Finalize a draft budget. Complete program design to include curriculum outline and site mapping. Submit a Sponsoring Institution (SI) application & receive initial accreditation.

To advance to the next stage: Achieve initial program accreditation – requires successful site visit and letter of accreditation from the ACGME.

To advance to the next stage: Complete contracts and orient first class of residents. Hire all required faculty.

RuralGME.org J Grad Med Educ. 2020 Aug;12(4):384-387. doi: 10.4300/JGME-D-19-00932.1.

Tips for Getting Started: Exploration

- Engage with the Community
  - Build a coalition of invested stakeholders
  - Assess readiness (varied stages)
- Explore Community Capacity
  - Identify assets and limits
  - Enlist leaders, physicians, staff
  - Explore partnerships

Credit: https://rttcollaborative.net/about/tools-and-assistance/

Recommended Webinars

Funding Questions

- Expand GME Training at Your Hospital
- Medicare GME Funding
- Impact of CMS Rule Changes on Rural GME (2 parts)

Governance and Hospital Support

- Value Equation for Rural GME
- Governance for Rural Programs
- GME Programs & Their Stakeholders

Specialty Development

- Accreditation for Rural Programs: FM, IM, and Psychiatry
- Creating and Sustaining Rural Surgery Tracks in Surgery and OB/GYN
- Rural Internal Medicine Program Development

Program Development

- Engaging Community Partners in New Program Development
- Faculty Recruiting and Development
- Faculty Competence
- Preparing Institutions for Learners

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