



INDIANA COMMISSION *for*
HIGHER EDUCATION

INDIANA GRADUATE MEDICAL EDUCATION BOARD

The 10-member Graduate Medical Education Board is tasked to award funds to entities expanding opportunities in Graduate Medical Education in Indiana. Appointed by the Governor, the Board can award funds to entities seeking to fund new residency program slots that will allow qualified individuals to complete residency programs in Indiana. To receive funds entities must be:

- Licensed hospitals seeking to fund new residency program slots in Indiana
- Nonprofit organizations seeking to increase residency program slots in Indiana

The \$6 million¹ Graduate Medical Education Fund was established by the Indiana General Assembly to fund qualifying entities selected by the Board. The Board can use these funds to:

- Provide funding for residents not funded by the federal Center for Medicare and Medicaid Services
- Provide technical assistance for entities that wish to establish a residency program
- Provide startup funding for entities that wish to establish a residency program.

AUTHORIZING LEGISLATION: 2015 House Enrolled Act 1323

GOVERNING STATUTES: IC 21-13-6.5
IC 21-13-7
IC 21-13-8

BOARD MEMBERS² (10 gubernatorial appointees):

Indiana University School of Medicine

Peter Nalin, MD – Executive Associate Dean for Educational Affairs, Indiana University School of Medicine

Indiana University School of Medicine, Regional Medical School Campus

Steven Becker, MD – Director and Associate Dean, Indiana University School of Medicine, Evansville

Marian University College of Osteopathic Medicine

Donald Sefcik, DO – Dean, Marian University College of Osteopathic Medicine

¹ \$3 million each year in FY 2016 and FY 2017

² Representatives appointed as required by IC 21-13-7



INDIANA COMMISSION *for* HIGHER EDUCATION

Indiana State Medical Association

James Buchannan, MD

Indiana Osteopathic Medicine Association

Mark Cantieri, DO – Private Practice and Clinical Assistant Professor, Marian College of Osteopathic Medicine

Indiana Primary Health Care Association

Beth Wrobel – CEO, HealthLinc

Teaching hospital in the Indiana Hospital Association

Paul Haut, MD –Chief Medical Officer, Riley Children’s Health

Non-teaching hospital in the Indiana Hospital Association

Tim Putnam - President/CEO, Margaret Mary Health, Batesville, IN

Medical Director of a Residency Program (2 Board Members)

Bryan Mills – CEO, Community Health Network

Tricia Hern, MD – Program Director, Community Health Network East Family Medicine Residency Program

INDIANA GRADUATE MEDICAL EDUCATION BOARD, MEETING DATES

- Tuesday, March 22
- Tuesday, May 17
- Thursday, July 7³
- Tuesday, August 16⁴
- Tuesday, October 18
- Tuesday, December 13

³ Special work-session; initial progress report presented to the Board by Tripp Umbach

⁴ Second progress report provided by Tripp Umbach



INDIANA COMMISSION *for*
HIGHER EDUCATION

INDIANA GRADUATE MEDICAL EDUCATION BOARD, VENDOR SELECTION PROCESS

- Week of March 28, 2016
 - RFP sent to minimum of three (3) potential vendors
 - RFP posted on Indiana Commission for Higher Education website
- Friday, April 29, 2016
 - Proposals due to Indiana Commission for Higher Education by 5pm EDT
- Week of May 2, 2016
 - GMEB Committee review of proposal submissions
 - Top-3 proposals selected based on criteria in scoring rubric and sent to full Board for review
- Week of May 9, 2016
 - Full Board evaluates proposal submissions
- Week of May 16, 2016
 - RFP discussed and voted on during 5/16/16 Board meeting



Project Deliverables Timeline

Friday, July 1 – Initial progress report due; progress update meeting between Vendor, Chairperson and Board¹

- Report to include:
 - Meetings held with stakeholders and feedback received
 - Initial data gathering and sources used to acquire data
 - Results of any focus groups, town halls, etc. related to the project
 - Updated timeline for completion

Friday, August 5 – 2nd progress report due; progress update meeting between Vendor, Chairperson and Board

- Report to include:
 - All information from initial report

Friday, August 16 – Briefing by vendor to full Board on project progress as part of 8/16/16 public GMEB meeting

Friday, September 16 – Final report due to Board²

Tuesday, October 18 – Board discusses report during meeting, votes to approve final product or request additional work by vendor

¹ Initial progress report provided during 7/7/16 work session

² During its 8/16/16 meeting the Board voted to extend the deadline to 10/18/16

Key Considerations Obtained from State and National Interviews
GME Expansion-Development Criteria
Provided by Tripp Umbach 8.12.16

GME Expansion Criteria	Notes
System and Hospital Leadership	There must be recognition at the highest level that academic medicine is worth the investment that hospitals and systems must make to start and support GME expansion, especially considering that CMS funding will not begin until well after funding for program development is required. GME is often more highly valued by institutions that are experiencing significant difficulties recruiting needed physicians, since a physician is more likely to establish a practice in the place where he or she has completed residency training.
Physician Leadership	There must be a physician champion who is qualified and willing to serve as the Program Director. For each specialty, ACGME outlines Program Director qualifications and the required time that must be allocated to the residency program. <i>(i.e., For Family Medicine: Program Director must have 5 years of family medicine clinical experience, including 2 years as core faculty in a family medicine residency program, and must allocate 70% of time to residency program responsibilities.)</i>
Faculty Engagement	There must be the appropriate number of physicians who are qualified and want to serve as core faculty to meet ACGME requirements. For each specialty, ACGME outlines the number of core faculty required and the required time that must be allocated to the residency program for each core faculty. <i>(i.e., For Family Medicine: At least 1 core faculty for every 6 residents, not including Program Director. Core faculty must allocate 60% of time to residency program.)</i>
Clinical Experiences	For each specialty, ACGME outlines specific requirements related to the volume and diversity of clinical experiences. <i>(i.e., For Family Medicine: Continuity care clinic is required with minimum of 1 preceptor for every 4 residents (if only 1 resident, 50% of 1 preceptor required) and 1,650 patient visits over 3 years.)</i>
High Quality FQHC Located Near Hospital	Although there can be challenges related to governance, FQHCs are often the best option for Family Medicine programs to meet Continuity Clinic requirements. FQHCs are required to offer comprehensive care, including mental health services, to underserved communities, must have ongoing quality assurance programs, and can provide interprofessional training opportunities. There are also clinical reimbursement advantages for Family Medicine practices located in FQHCs.
CMS GME Funding Cap	CMS provides funding for GME to hospitals in the form of Direct GME (DGME) and Indirect GME (IME) payments. IME payments tend to be higher than DGME payments. Both types of payments are determined by specific formulas that take into account (among other things) the number of residents that CMS has determined to be eligible for funding. In general, funding to hospitals with existing programs in 1996 has been capped at the number of residents training at that time. However, hospitals starting Rural Training Tracks are allowed exceptions to this cap and can receive additional funding for residents training in rural sites. Hospitals developing GME programs for the first time are given a 5 year period to build a cap, and are thus financially incentivized to create as many resident training positions as possible during that time.

GME Expansion Criteria (continued)	Notes (continued)
Medicare Patient Volume	DGME payment formulas are dependent upon what percentage of all inpatients are Medicare patients, since CMS only wants to pay for its “share” of GME costs. The higher the percentage, the more favorable the payment. IME payment formulas are dependent upon the amount of Medicare revenue received by the hospital since IME payments are an “add-on” to Medicare patient care payments to the hospital.
Sole Community Provider Designation	Hospitals receiving funding from CMS because they are a Sole Community Provider cannot also receive IME payments from CMS; CMS considers that “double dipping” as these two funding sources are thought to address the same types of issues.
Rural Designation	Existing caps can be increased if new residency programs are started at rural hospitals (but not for existing programs hosted by the rural hospital that are expanded).
Rural Training Track Potential and Distance	Existing programs can develop one or more Rural Training Tracks (RTTs). Typically, RTT residents train for approximately one year in a more urban setting, and two years in a rural* location. ACGME requirements for RTT programs are the same as for other programs, except that the minimum requirement of residents in the program is waived. RTT residents may complete any training at the urban site as long as residents have a minimum of 20 months of shared training experience in the rural location. While challenges include distance from the hub of academic activity (currently, no distance limits have been established by ACGME), faculty development and support for rural physicians can be provided by the urban program. RTTs provide existing programs an exemption from their CMS funding cap and better prepare residents planning to practice in a rural location. RTT residents are more likely to establish practices in rural areas after completion of residency training.
Community Desirability	It is easier to recruit both residents and faculty to communities that are considered desirable and have affordable housing, employment opportunities for the partners of residents and faculty, and high quality schools.
Relationships Between Hospitals with Existing GME Programs and Hospitals with Potential to Develop New Programs	Because GME expansion requires significant support from leadership at both the system and hospital levels, positive relationships between hospitals are an advantage. Sometimes GME expansion can help build and enhance existing relationships that one or both parties are hoping to improve, since education is often perceived to exist outside of other competitive issues.

*Rural is defined as a location that has a Rural Urban Commuting Area (RUCA) code of 4 or greater, except 4.1, 5.1, 71, 8.1, and 10.1.