A Recommendations Report to Governor Brian Sandoval

By

The Governor's Graduate Medical Education Task Force

June 25, 2014

GME Task Force Members:

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Governor's Graduate Medical Education Task Force
Recommendations

June 25, 2014

SUMMARY:

On March 11, 2014, Governor Brian Sandoval issued **Executive Order 2014-07** establishing a Task Force for Graduate Medical Education (GME) with a directive to develop a proposal that outlines a plan for the investment of state budgeted funds for the 2015 legislative session to expand GME in the state of Nevada to meet our growing healthcare needs and lack of medical specialty expertise.

The Task Force conducted a review of federal GME policies as they impact public and private GME sponsoring entities, GME allocated positions within the state, existing GME strengths, gaps in GME subspecialty areas, the overall healthcare provider environment as well as a state and national assessment of future healthcare of Nevadans.

The fundamental conclusion of the Task Force is that Nevada is underserved in most areas of healthcare delivery in both urban and rural settings. The state needs more doctors, nurse practitioners, physician assistants and nurses. Population demographics across the state are lacking appropriate healthcare services.

The most direct contributing factor to Nevada's poor rankings are the shortages of healthcare providers; specifically physicians. It has already been well established that the majority of doctors stay and practice in the vicinity of their GME training. Efforts in recruiting physicians from other states continue but are difficult, costly and unpredictable. Another source of incoming physicians is needed; and that source can be more GME programs in Nevada. A 2006 report by LarsonAllen, an independent Minnesota consulting firm charged with reviewing Nevada medical education capacity and need, recommended that the state develop graduate medical education training opportunities because the existing medical education system cannot keep up with growing need.

Currently, there are two fully accredited medical schools in Nevada that graduate approximately 200 medical students each year. There are approximately 160 first year residency positions for the 200 graduates. This means that if every one of those 200 graduates planned to receive GME training in Nevada, at least 40 of them would have to leave the state to obtain a GME position. The reason GME is so critical is because GME training is required in all 50 states to obtain medical licensure to practice medicine. In 2016, a third medical school (Roseman University) is slated to open its doors and by 2020, potentially another 50 – 100 students could be graduating. With the possibility of yet a fourth medical school in Nevada, (UNLV), the percentage of first year residency positions for Nevada's medical school graduates will continue to decline. Although this problem cannot be completely fixed, it can be alleviated with the creation of more GME positions.

CONSENSUS REPORT:

The Task Force voted by majority consensus on the following recommendations:

- Graduate Medical Education (GME) programs need to be expanded and new programs created.

Currently, Nevada is one of the states with the lowest rate per capita of active primary care physicians, along with Mississippi, Utah, Texas and Idaho, according to the Association of American Medical Colleges. The need for more doctors is so critical that the development of medical education, physician recruitment and retention efforts must begin immediately to produce physicians that will remain in Nevada, assuring both public health and economic opportunity for all residents. The State of Nevada must expand its medical education, research and clinical missions in order to meet growing needs.

Financial support of GME is necessary to ensure the continued supply of well-trained physicians required to improve the health and well-being of our residents. Public funding of GME should encourage physician training that supports better care which leads to better health outcomes and lower costs. Strong collaborative relationships and unity of purpose are key factors in fulfilling the ultimate vision of improved healthcare access, improved quality of care and sustainable economic impact statewide.

- A diverse organization should be established by the Governor to determine recommendations for the distribution of the funds.

Most states do not report any coordination at the state level for GME decision-making, or any coordinating body that guides the number, location or specialty of new residency positions. The Governor's GME Task Force, established by **Executive Order 2014-07**, is a step in a new direction that is both innovative and responsible to the healthcare needs of Nevadans.

Moving forward, the GME Task Force recommends a diverse committee of stakeholders charged with the task of developing criteria by which funds would be awarded for the expansion of existing GME training programs, improved quality of existing programs so as to enhance the success of recruiting Nevada medical students or the development of new training programs. The criteria selected would be influenced by the following:

  - state need,
  - student demand for the specialty program proposed,
  - the availability of hospital partners and clinical training resources,
  - the long-term commitment of the institutions involved,
  - the past GME experience of the applicant institutions,
  - the ability to support the maintenance costs of the program following start-up,
  - an assessment of likely success,
  - and the economic impact of the graduates anticipated from the expanded/new programs.

Preference could be shown for programs emphasizing particular shortage areas, such as primary care and mental health, with the potential for expansion to other specialties as demand is established.

- All methods for expansion and funding, such as state funds, federal funds, money leveraging, unused GME slots, private funds, etc. should be considered further.

The debate on how best to finance the expansion of GME in Nevada will require additional planning. The dominant public funder of GME is Medicare with Medicaid and the Veterans Administration contributing significantly. The state can play a significant role in how GME is funded to address the needs of physicians in both rural and urban health professional shortage areas.

Mike Willden, Nevada Director of Health and Human Services, presented to the Task Force on "*Possible non-state general fund financing opportunities to support GME and leveraging HHS funding.*" The presentation has been added to this report and can be found in **Appendix 1**.

- Further discussion should continue on how funds are specifically used for GME, such as creating new programs and expansion of current programs, including all accredited GME sponsoring institutions, focusing on all healthcare gaps, improving the quality of programs, and supporting teaching health centers. Measures should be taken to ensure continuation of funds.

Bill Welch, Executive Director of the Nevada Hospital Association, provided a report on "*Nevada Hospital GME Needs.*" This submission has been added to this report can be found in **Appendix 2**. The exhibits within the report demonstrate suggested relational guidelines that can be used to determine hospital GME readiness. Other exhibits outline approximate costs for GME expansion of current programs in addition to the start-up costs associated with new programs.

The goal would be for proposals to be solicited from all accredited GME-sponsoring institutions in Nevada shortly after funds are known to be available following the 2015 state legislative session. Programs should be expected to show the potential for expansion as soon as July 2016, or for new programs to be developed by July 2017.

- Accountability measures will need to be determined by the Governor created organization.

The Task Force strongly recommends the development of performance metrics by which the impact of potentially awarded funds would be measured. Quantitative metrics should be established and monitored to allow for continuous data collection on the evolving healthcare workforce to assess changing needs as well as to establish accountability metrics to track the spending of public GME funds.

- There will be no stipulation as to the type of sponsor program, whether allopathic or osteopathic, private or public entity.

The Task Force agreed that both allopathic and osteopathic sponsored GME programs are in need given our physician shortages and the need to further develop Nevada's physician workforce pipeline. Additionally, both public and private institutions were seen as having an equal stake in solving Nevada's physician shortages through GME expansion efforts.

- Entities other than hospitals need to be encouraged to expand or create new programs.

According to a March 25, 2014 Commonwealth Fund report, Nevada has among the highest percentage of the under-65 population who are either uninsured or underinsured. According to the report, the five highest-rated states were Idaho, Florida, Nevada, New Mexico and Texas. Many of these patients receive healthcare at the county hospital, federally qualified health centers, volunteer clinics or other safety net or pseudo-safety net local health care facilities. Many of these patients are receiving this healthcare from resident physicians who are rotating through these locations. Increased GME positions and collaborative efforts between institutions can increase the number of resident physicians in these locations and thus increase healthcare access to this population.

A member of the Nevada Primary Care Association presented data on the role of Nevada federally qualified health centers/community health centers (CHCs). Nevada has (4) community health centers with (23) sites in (11) counties. Services include primary medical care, dental care, integrated behavioral health services, and homeless outreach medical services. In 2013, there were 72,100 patients served; noting 97% below poverty level, 46% uninsured and 29% Medicaid. Select Nevada CHCs currently have partnerships with UNSOM Department of Psychiatry and UNR Department of Psychology to provide fellowship training for adult and child/adolescent mental health services. Other positions supported include advanced practice nursing students, physician assistant students and social work interns.

The Task Force recommends the formation of consortium models of GME where (2) or more hospitals share resources including facilities, administration, faculty, costs, etc. This approach could very well include the addition of CHCs throughout Nevada adding an outpatient clinical experience to the inpatient hospital setting to maximize training opportunities. A current example of shared GME includes a partnership among UMC, UNSOM and the Veterans Administration to expand psychiatry residency slots in southern Nevada.

- Department of Health and Human Services will have oversight of the accounting for the funds but will not determine the distribution.

The Task Force strongly recommends the continued participation of the Nevada DHHS as the fiduciary agency for accounting of state GME funding. As noted in **Appendix 1**, there are several opportunities to leverage and maximize potential state GME funds with other revenue streams. The recommended Governor formed organization would provide programmatic oversight as well as the determination for the distribution of state GME funding.

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Recommendation Number	GME Task Force Members Final Recommendations June 6, 2014 The Task Force found consensus with the items highlighted in green.	Number of members commented	Schwenk	Tellez	White	Forman	Hardy	Welch	Penn	Park	Thom	Farrow			
	Management/ Accountability provided by:														
1	Unnamed Governance structure/committee	4						x	x		x	x			
2	Centrally managed by Task Force GME Governance (11 board members) and decentrally executed	3		x			x			x					
3	Already established NSHE Steering Committee, NSHE Chancellor, NSHE Board of Regents to manage all aspects	2	x		x										
4	DHHS to manage money from State or other sources until appropriate applications are deemed viable to start a residency	1					x								
	Funding acquired through														
5	State funds (appropriated by the State Legislature, $12M)	6	x	x	x	x			x			x			
6	Federal funds	6	x	x	x	x			x			x			
7	Money leveraging: Inter-governmental transfers, Tobacco settlement funds, fees, fines, and assessments, provider tax, etc.	3		x					x			x			
8	Unused GME slots for existing successful GME programs with capacity to grow	3		x		x			x						
9	Private funds	2		X					x						
	Funds to be used by/for:														
10	Expanding programs	9	x	x	x	x	x	x	x		x	x			
11	New Programs	9	x	x		x	x	x	x	x	x	x			
12	All accredited GME-sponsoring institutions	5	x	x	x	x			x						
13	Consortiums/Collaborative programs	5		x		x	x			x		x			
14	state need--primary care and mental health	5	x			x	x	x				x			
15	state need--other medical specialty gaps (after considering primary needs, student needs)	5	x	x	x	x		x							
16	improve quality of programs	4	x		x	x						x			
17	Training other healthcare providers (Physician Assts, Nurse Practioners and Nurses)	2			x				x						
18	Out patient focused entities (Community Health Ctrs/FQHCs)	2					x					x			

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19	incentive eligible heatlh care institutions to create new GME programs wit a one-time grant for start up dollars.	2						x		x					
20	Undergraduate Medical Education (UME)	1			x										
21	Public Institutions only	1			x										
22	Hospitals only	1						x							
23	Teaching Health Centers (same as #18)	1				x									
	Criteria upon which to determine if/how funding should be awarded:														
24	Respectful of CMS, and Residency Allocation Capitations set forth by ACGME and governing boards (critical to maximize the 5 year CAP on growth)	3		x		x		x							
25	Evidence of evaluated clinical experience/volume of patients, commitment and readiness to establish/expand residency training program and demonstrate the financial sustainability of the program being proposed; Existence of Medicare beds, DME, program directors, potential faculty	3	x	x				x							
26	Agree to annual reporting of progress update, financial report, and measurable outcomes of the residency being implemented (i.e. new residents trained, etc.).	3					x	x		x					
27	the availability of hospital partners and clinical and teaching resources	2	x			x									
28	Applicants must provide a detailed proposal that includes specific start-up costs being requested, estimated time for first residents to be trained, number and specialty of residents to be trained, and a detail proposed operating budget	2	x				x								
29	student demand for the specialty program proposed	1	x												
30	negotiate funding to hospitals that might include full or partial repayment of start up costs once CME revenue begins	1				x									
31	the past GME experience of the applicant institutions	1	x												
32	the economic impact of the graduates anticipated from the expanded/new programs.	1	x												
33	Clinical rotations within NV's local, state and federal medical centers and institutions	1			x										

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34	Priority will be given to at least 3 New Residency Programs at new GME hospitals or other clinical sites for start-up funding requests to the extent applications meet the additional requirements	1						x							
35	Priority to requests to expand in Nevada's physician shortage specialties (internal, family, and pediatric medicine, psychiatry, and general surgery).	1						x							
36	GME start up funds coordinated with current and future state-supported UME programs				x										
	Application Process														
37	Advance notice to potential applicants of potential funds, 30 days notice prior to application deadline	1						x							
38	Funding awards that meet or exceed the criteria below will occur within 45 days of the close of the application process.	1						x							
39	Remaining funds follow the same process each year	1						x							
40	Any proposal can not receive more than the lower of the approved amount or the actual costs expended (if subsequent to the application approval, either the estimated cost aren't incurred or CMS later provides funding, previously approved funding must be refunded to the GME Pool).	1						x							
	Outcomes measures/Quality indicators														
41	Annual reporting provided by the applicant and governing group including progress update, financial report, and measurable outcomes of the residencies being implemented, satisfaction of partners, sustainability, monies leveraged	6	x		x			x	x		x	x			
42	Retention of doctors and residents	3			x	x					x				
43	Factors influencing physicians career(school through practice)	1			x										
44	Continuous data collection on evolvoing workforce to assess changing needs	1			x										

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	Other considerations														
45	Initial start up costs ($3M, see also Mr. Welch's table)	2					x	x							
46	Hospitals already identified as potential GME sites could be encouraged to make due diligence to do GME	1					x								
47	Protect state funding for future GME funds	2				x	x								
48	explore how to use Western Interstate Commission for Higher Education (WICHE) to facilitate and enhance GME	1					x								
49	Provide deep appreciation for the Governor's support in finding solutions to the GME challenges in Nevada	1							x						
50	Need more exploration and study	1							x						
51	Emphasize time from availability of $s to the impact on the # of physicians in GME, and then practicing in Nevada, will be several years; so early returns may be low	1							x						
52	Applicants make at least a 4 year commitment to fund any shortfalls	1			x										
53	time-line for starting a program is 18-24 months, likely longer	1				x									
54	GME expansion over UME expansion	1				x									
55	State funds ($9M to So. NV; $3M to Rurals/No. NV)	1			x										
56	Approx. 200 NV graduates annually, fewer than 20% do residencies in NV	1			x										
57	Nearly 1/2 of non-residents are graduates of foreign medical schools, denoting Nevada GME programs are not highly sought after by medical school graduates.	1			x										
58	A large portion of UNSOM graduates leave to pursue residencies in specialities not offered in NV	1			x										
59	Limited producion of physicians, low numbers of GME training positions, few GME subspecialities and low retention rates of non-state residenceleads to critical shortages, loss of residents to other states and poor healthcare options.	1			x										

Appendix 1

POSSIBLE NON-STATE GENERAL FUND FINANCING OPPORTUNITIES

TO SUPPORT GME AND LEVERAGING HHS FUNDING

Presented by

Mike Willden, Director
Nevada Department of Health and Human Services

POSSIBLE NON-STATE GENERAL FUND FINANCING OPPORTUNITIES TO SUPPORT GME AND LEVERAGING HHS FUNDING

MEDICAID GME FINANCING

Medicaid programs are not required to provide support for GME, but if they do they are eligible for federal matching funds (FMAP). Nevada Medicaid currently enjoys an FMAP rate of 63%. In other words, if Medicaid makes GME payments the non-federal share of the payments would only be 37%. It makes great fiscal sense to leverage FMAP for GME if possible.

Potential sources (ideas) of non-federal revenues are:

Inter-governmental transfers (IGTs): This source of funding is currently used to finance the Public Hospital GME program. Clark County transfers funds to NV Medicaid to support the GME payments made to University Medical Center (UMC). This program could be expanded if there is room under the Public Hospital Upper Payment Limit (UPL) gap. IGTs could be accepted from other governmental sources (University, DHHS, DETR, GOED, etc.) to support GME payments. IGTs must be voluntary payments per federal rules.

Reallocation of Net State Benefit from the Private Hospital UPL program: Nevada DHHS, in cooperation with the private hospitals, recently started a private hospital UPL program. A "needy care collaborative" known as Nevada Clinical Services (NCS) was established to assist with the financing mechanics. Contractual services that NVDHHS has historically paid for are ended and payment responsibility is transferred to NCS. This frees funding within DHHS budgets that can then be leveraged with federal funds to make UPL payments. Within this process DHHS keeps a portion of the funds known as the "net state benefit" for reversion to the State General Fund. This process (AB 507) could be revisited and used to support GME.

> **Sec. 51.** 1. The Department of Health and Human Services may, with the approval of the Interim Finance Committee upon the recommendation of the Governor, transfer from the various divisions of the Department to an account which is hereby created within the State General Fund any excess money available to the divisions as a result of savings from not providing health and related services, including, without limitation, savings recognized by using a different source of funding to pay the providers of services if the persons previously served by a division no longer require the provision of services from the division of the Department.
> 2. Any money transferred to the account created by subsection 1, to the extent approved by the Centers for Medicare and Medicaid Services and authorized by the State Plan for Medicaid, must:
> (a) Be used to pay administrative and related costs and the State's share of the cost for the expansion of the upper payment limit program as provided in this section.
> (b) After being used to satisfy the requirements of paragraph (a), be reserved for reversion to the State General Fund and must be reverted to that Fund at the end of each fiscal year of the 2013-2015 biennium.

Tobacco Settlement Funds: Each year NV DHHS receives approximately $24 million in funding from the Tobacco Settlement. These funds are distributed to a number of programs supporting seniors, disabled, tobacco cessation, children's services, mental health programs and general wellness. Although the funding is generally fully distributed each year; a policy decision could be made to earmark Tobacco funds to support GME.

Fees, Fines and Assessments: Several DHHS programs are funded though fees and assessments, or penalties paid (birth and death certificates, application fees for licenses, non-compliance penalties, etc.). These sources could be reviewed and adjusted to support GME.

Provider Tax: Medicaid programs can use provider taxes as a revenue stream to fund programs/services. An example in Nevada is the 6% tax on net patient revenue on free standing nursing facilities. The revenue stream is used to match federal funds to make enhanced/quality payments to the nursing facilities. Provider taxes could support GME.

BLOCK GRANTS

Nevada DHHS receives several federal block grants to support various health and wellness programs. Examples are; Preventative Health Grant, Maternal and Child Health Grant, and the Mental Health Block Grant. These grants could be reviewed and potentially used to support GME. It is not likely these funds could be matched with Medicaid funds.

VETERANS ADMINISTRATION

The VA is an important source of GME funding and training capacity. Approximately 30% of the nation's medical residents receive training at the VA each year. We need to ensure we are fully leveraging this opportunity in Nevada.

HEALTH RESOURCE SERVICES ADMINISTRATION

HRSA provides several different types of GME grants that operate outside of the CMS GME funding mechanisms. Nevada is not listed in the chart (shown below) provided in the University of North Carolina's September 2013 report summarizing these programs. Why isn't or can't Nevada leveraging these resources?

Table 1: HRSA funding by program type and state

State	2013 HRSA Teaching Health Center[1]	2010 HRSA Primary Care Residency Expansion[2]	2013 HRSA Children's Hospitals GME[3]	2013 HRSA Preventive Medicine Residencies[4]	2012 HRSA Integrative Medicine Program[5]
CA	X	X	X		X
FL		X	X		
GA			X		
ID	X	X			
IL	X	X	X		
MA	X	X	X	X	X
MD		X	X		X
MI	X	X	X	X	X
MT	X	X			
NC	X	X		X	X
NJ		X	X		X
NY	X	X	X		
TN		X	X	X	X
TX	X	X	X		
UT			X	X	
VT					
WA	X	X	X		

[1] Active Grants for HRSA Program(s): Affordable Care Act Teaching Health Center (THC) Graduate Medical Education (GME) Payment Program (T91). Accessed online 22 July 2013: http://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=T91&rs:Format=HTML4.0.

[2] Active Grants for HRSA Program(s): Affordable Care Act: Primary Care Residency Expansion (T89). Accessed online 22 July 2013 at: http://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=T89&rs:Format=HTML4.0.

[3] US Department of Health and Human Services, Health Resources and Services Administration. 2013. Report to Congress: Children's Hospitals Graduate Medical Education (CHGME) Payment Program. Accessed online 22 July 2013 at: http://bhpr.hrsa.gov/childrenshospitalgme/pdf/reporttocongress2013.pdf.

[4] Active Grants for HRSA Program(s): Preventive Medicine Residencies (D33). Accessed online 22 July 2013 at: http://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=D33&rs:Format=HTML4.0.

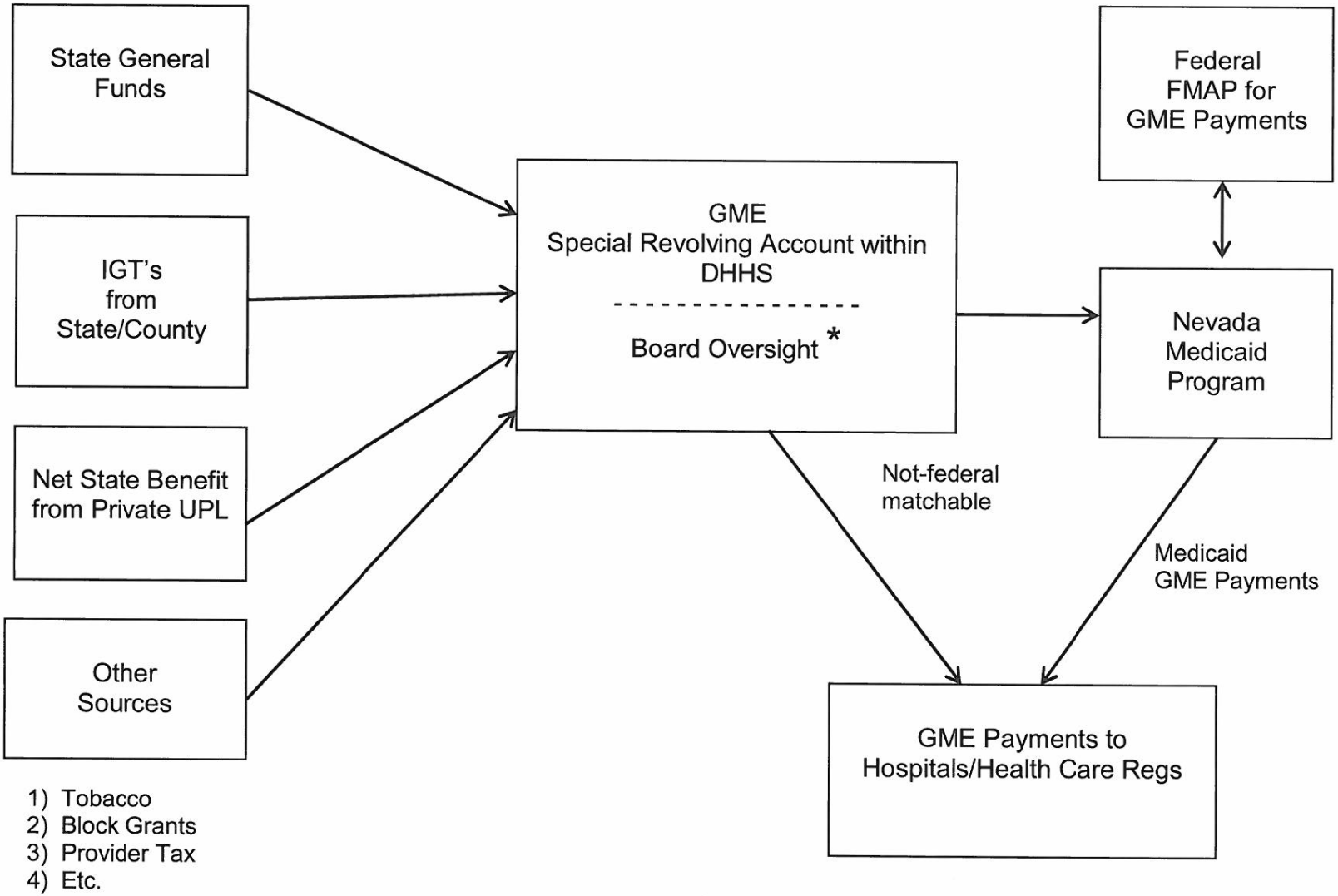
[5] Active Grants for HRSA Program(s): Integrative Medicine Program (IMO). Accessed online 22 July 2013 at: http://ersrs.hrsa.gov/ReportServer/Pages/ReportViewer.aspx?/HGDW_Reports/FindGrants/GRANT_FIND&ACTIVITY=IMO&rs:Format=HTML4.0.

THIRD PARTY PAYERS/FOUNDATIONS/SETTLEMENTS

A few states are tapping into non-governmental resources to support GME. A concerted effort in Nevada to raise funds for GME from these sources may be fruitful. A specific recommendation in this area is to work with the Attorney General's Office to ensure they are aware of the Taskforce's efforts and to determine if GME could become a recipient of future settlement funding obtained by the AG's Office (examples: past United Health Settlement and Drug Manufacturer Settlements).

#2

Graduate Medical Education (GME)
Fiscal Management Concept



*Establish 11 member board to administer GME program (4 universities, DHHS, GOED, Hospitals, Governor and Legislative Appointees)

Appendix 2

NEVADA HOSPITAL GME NEEDS

Presented by

Bill Welch, Executive Director
Nevada Hospital Association

Nevada Hospital Association
Nevada Hospital GME Needs
May 30, 2014

Challenges to growing GME in Nevada hospitals:

1. Most of the hospitals with the breadth and volume of clinical experience needed for both training and funding purposes are capped from a CMS funding perspective. See Exhibit 1 for potential candidates for new GME programs
2. Currently, the State of Nevada doesn't provide any funding to private hospitals to support its" proportionate share of GME costs.
    a. In addition, Nevada hospitals already subsidize on average 48% of the cost of care they provide to Medicaid recipients and those recipients are have grown by more than 50% in the last year due to health care reform.
    b. Asking hospitals to take on the financial responsibility for expanding GME is not viable in most cases.
3. The vision, time and readiness to grow GME (hospitals, medical schools, and community physicians) is a significant effort and must be not be taken lightly due the CMS funding caps.
4. To maximize funding and minimize wasted time, any process to grow GME should work to ensure program approval in the spring in time for the fall resident interview and following matching process and would need to make funding available accordingly.

Resources Needed:

One time resources: Given there are many needs and options to grow GME programs in Nevada, we have included examples for both start up and operational support (See Exhibits 2 - 4 attached) for a 60 resident program that includes psychiatric, family medicine, and internal medicine residents. The operational example is based on experience of multiple hospitals currently involved in GME across the state.

New Residency Program/New GME Hospitals: While this method of expansion takes the longest to accomplish, once hospitals with adequate volume, clinical experience and payer mix are identified, it is potentially the most likely to be viable over time. The resources needed in this circumstance will be used for start up costs prior to any resident training. Although the on-going operational costs related to a new residency program are significant ($ 20,871,000 for this 4 year program– see Exhibit 3 attached), once residents begin training, new programs can begin receiving GME payments.

See Exhibit 2 - **Start up costs** prior to resident training approximate **$1,400,000 to $2,200,000** depending on the time it takes to implement.

New Residency Program/Existing GME Hospitals – This option takes advantage of the existing infrastructure of an existing GME program (unless the number of residents is increased significantly). Since these facilities are capped from a CMS funding perspective, the one-time costs is primarily the high cost of funding direct medical education including salaries, benefits, malpractice cost of residents and the incremental faculty and support staff associated with training more residents until such time as redistributed CMS funded slots can be obtained. In addition, there will likely be some portion of start-up costs but it would likely be limited to Program Director time needed to submit the initial application but would vary depending on the specialty of the new program.

Start up costs: $130,000 - $180,000 (see Exhibit 2)
Operational costs: $6,708,000 See Exhibit 3 – with the example of a new 18 resident Internal Medicine program four years of cost the following is an estimate of the one-time resources:

Expanding Residency Program/Existing GME Hospitals – This option is probably the most flexible and quickest to accomplish but also has the high cost of funding direct medical education including salaries, benefits, malpractice cost of residents and the incremental faculty and support staff associated with training more residents until such time as redistributed CMS funded slots can be obtained.

See Exhibit 4 attached – using the example of expanding 18 residents in an Internal Medicine program the following is an estimate of the one-time resources:

Operational costs: $6,375,000

Note: While 4 years of operating funds have been included in both examples of expanding residencies in existing GME hospitals since we believe this minimum commitment is need to be made by all parties to meet the commitment to the residents matching to the program, the program may receive redistributed CMS funded slots earlier and not need all the funds initially requested. On the other hand, if CMS funded slots are not obtained, there is a risk that the expanded residency slots will be eliminated over time.

On going resources:
As noted above, Medicaid does not reimburse hospitals it's proportionate share of GME expenses. Going forward, we recommend, that Medicaid consider funding similarly to the method Medicare uses to reimburse for hospitals for GME.

How soon can Nevada hospitals be training more residents?

	Allopathic	Osteopathic
New Residency Programs/New GME Hospitals	3 years	1.5 years
New Residency Program/Existing GME Hospitals	2-3 years	1 year
Expanding Residency Program/Existing GME Hospitals	6-12 months	6-9 months

Summary:

We recommend that the taskforce consider a blended approach to growing GME in Nevada. Using resources to both to establish new GME programs and expand existing programs addresses the short term need of getting residents into training quickly in existing programs as well as ensuring resources are invested new programs for the longer term development of GME. We also recommend that state reestablish an on-going Medicaid reimbursement program to fund its proportionate share of GME costs.

Nevada Hospital Residency Analysis
Utilization-Volume

EXHIBIT 1

South:	(>6,000) Medicare Admits*	(>15,000) Total Admits*	(>40%) Medicare Utilization	(>1) Severity Adjusted CMI**	
Centennial Hills Hospital Medical Center	3,825	10,178	38%	1.19	
Desert Springs Hospital Medical Center	6,393	11,143	57%	1.33	
MountainView Hospital	9,142	17,232	53%	1.33	***
North Vista Hospital	2,996	5,820	51%	1.07	
Southern Hills Hospital and Medical Center	3,090	6,979	44%	1.22	
Spring Valley Hospital Medical Center	5,631	14,332	39%	1.33	***
St. Rose Dominican Hospitals - Rose de Lima Campus	3,647	6,029	60%	1.16	
St. Rose Dominican Hospitals - San Martin Campus	3,003	6,951	43%	1.3	
St. Rose Dominican Hospitals - Siena Campus	6,766	16,345	41%	1.43	***
Summerlin Hospital Medical Center	6,682	17,903	37%	1.26	***
Sunrise Hospital and Medical Center	9,337	28,016	33%	1.43	
University Medical Center of Southern Nevada	4,299	24,124	18%	1.45	
Valley Hospital Medical Center	6,135	14,685	42%	1.39	
South Total	**70,946**	**179,737**	**39%**		
Rural:					
Banner Churchill Community Hospital	807	1,849	44%	0.92	
Battle Mountain General Hospital	18	32	56%	0.97	
Boulder City Hospital	271	381	71%	0.81	
Carson Valley Medical Center	532	795	67%	1.05	
Desert View Regional Medical Center (2Qtrs)	243	694	35%	0.76	
Grover C Dils Medical Center	113	147	77%	0.83	
Humboldt General Hospital	261	873	30%	0.86	
Incline Village Community Hospital	1	6	17%	0.63	
Mesa View Regional Hospital	381	720	53%	0.96	
Mount Grant General Hospital	297	458	65%	0.72	
Northeastern Nevada Regional Hospital	858	2,797	31%	0.95	
Nye Regional Medical Center	34	70	49%	0.95	
Pershing General Hospital	46	64	72%	0.74	
South Lyon Medical Center	73	126	58%	0.76	
William Bee Ririe Hospital	138	404	34%	0.9	
Rural Total	**4,073**	**9,416**	**43%**		
North:					
Carson Tahoe Regional Medical Center	5,310	10,374	51%	1.24	***
Northern Nevada Medical Center	2,188	3,639	60%	1.14	
Renown Regional Medical Center	10,786	27,217	40%	1.44	
Renown South Meadows Medical Center	1,635	2,906	56%	1.12	
Saint Marys Regional Medical Center	6,726	15,192	44%	1.24	***
North Total	**26,645**	**59,328**	**45%**		
State Total	**101,664**	**248,481**	**41%**		

Current GME Programs

* Per NHQR for CY 2013

** Per Intellimed, for FY ended 6/30/2013.

***Full service acute care hospitals - may have the clinical experience and ability to be financially viable.

Areas of concern to evalute related to volume or clinical experience

Additional Notes:

St. Rose Siena - currently has an Orthodontic program which is not under the CMS capping rules

Humbolt General Hospital - has an approved GME program that is in the start up phase.

VA hospitals are not listed on this report and are not funding in the same manner from CMS.

Categorical guidelines used are relational and can be adjusted up or down

For example, overall admission may be lower than 15,000 but % of Medicare utilization is higher than 40% (Valley Hosp.)

START UP COSTS FOR NEW GME PROGRAM
INCLUSIVE OF APPLICATION DEVELOPMENT, SUBMISSION, AND APPROVAL PLUS INITIAL PROGRAM DEVELOPMENT/

EXPENSES FOR NEW GME HOSPITAL **EXHIBIT 2**

	18 months	36 months
Salaries:		
Director of Medicdal Education -DME		
Program Director (PD) Internal Medicine		
PD Family Medicine		
PD Psychiatry		
GME Staff- Manager and Coordinator		
Total salaries	$ 750,000	$ 1,500,000
Infrastructure:	$ 600,000	$ 600,000
Inclusive of construction for call rooms, lecture auditorium, conference room, offices, resident library, study areas		
Operations:	$ 72,228	$ 72,228
Inclusive of software programs, didactic materials, licenses, dues, leases, resident supplies, computers, recruitment		
Total Start Up Costs	**$ 1,422,228**	**$ 2,172,228**

EXPENSES FOR NEW RESIDENCY/ EXISTING GME PROGRAM	12 months	24 months
Program Director MD	$ 50,000	$ 100,000
Program coordination (12 month prior to start)	$ 55,000	$ 55,000
Operations:	$ 25,000	$ 25,000
Inclusive of software programs, didactic materials, licenses, dues, leases, resident supplies, computers, recruitment		
Total Start up Costs	**$ 130,000**	**$ 180,000**

NEW GME PROGRAM
60 RESIDENTS IN 4 YEARS

EXHIBIT 3

Psychiatry: 4 yrs- 6 residents/yr	Direct Resident Exp		Faculty/ Staff Exp		Overhead Exp		Total Cost/Yr	Total Cost by Program/ 4yrs
Year 1 Salary, benefits, med mal	66,324 x 6	397,944	26,149 x 6	156,894	31,000 x 6	186,000	740,838	
Year 2	66,324 x 12	795,888	26,149 x 12	313,788	31,000 x 12	372,000	1,481,676	
Year 3	66,324 x 18	1,193,832	27,267 x 18	490,806	31,000 x 18	558,000	2,242,638	
Year 4	66,324 x 24	1,591,776	27,267 x 24	654,408	31,000 x 24	744,000	2,990,184	$ 7,455,336
Family Med: 3 yrs-6 residents/yr								
Year 1 Salary, benefits, med mal	66,324 x 6	397,944	26,149 x 6	156,894	31,000 x 6	186,000	740,838	
Year 2	66,324 x 12	795,888	26,149 x 12	313,788	31,000 x 12	372,000	1,481,676	
Year 3	66,324 x 18	1,193,832	27,267 x 18	490,806	31,000 x 18	558,000	2,242,638	
Year 4	66,324 x 18	1,193,832	27,267 x 18	490,806	31,000 x 18	558,000	2,242,638	$ 6,707,790
Internal Med: 3 yrs-6 residents/yr								
Year 1 Salary, benefits, med mal	66,324 x 6	397,944	26,149 x 6	156,894	31,000 x 6	186,000	740,838	
Year 2	66,324 x 12	795,888	26,149 x 12	313,788	31,000 x 12	372,000	1,481,676	
Year 3	66,324 x 18	1,193,832	27,267 x 18	490,806	31,000 x 18	558,000	2,242,638	
Year 4	66,324 x 18	1,193,832	27,267 x 18	490,806	31,000 x 18	558,000	2,242,638	$ 6,707,790
Year 1 Total Cost: 18 residents		ADME + two staff					2,222,514	
Year 2 Total Cost: 36 residents							4,445,028	
Year 3 Total Cost: 54 residents		Add one staff					6,727,914	
Year 4 Total Cost: 60 residents							7,475,460	
Total Costs: 4 years							**$ 20,870,916**	$ 20,870,916

USED TO DETERMINE COSTS FOR NEW GME PROGRAM
AVG COST OF GME FTE/YEAR

Salary (4 yr avg) - 2014	48,500	
Benefits /FTE (28%) - 2014	13,580	
Med Mal Avg/FTE - 2014	4244	
Sub Total	**66,324**	
Operational Cost Avg/FTE/Yr-2014	5,021	supplies/materials/ recruitment/coat/
Faculty Avg/FTE/Yr- 2007-2010	23,365	Average/FTE of first four years of Program
Staff Avg/FTE/Yr - 2014	2,464	
Sub Total	**30,850**	

ADD TO CURRENT GME PROGRAM
60 ADDITIONAL RESIDENTS

Exhibit 4

Psychiatry: 4 yrs- 6 residents/yr	**Direct Resident Exp**	**Faculty/ Staff Exp**		**Overhead Exp**		**Total Cost/Yr**	**Total Cost by Program/ 4yrs**
Year 1 Salary, benefits, med mal	66,324 x 6	397,944	23,785 x 6	142,710	31,000 x 6	186,000	726,654	
Year 2	66,324 x 12	795,888	21,579 x 12	258,948	31,000 x 12	372,000	1,426,836	
Year 3	66,324 x 18	1,193,832	19,948 x 18	359,064	31,000 x 18	558,000	2,110,896	
Year 4	66,324 x 24	1,591,776	19,451 x 24	466,824	31,000 x 24	744,000	2,802,600	$ 7,066,986
Family Med: 3 yrs-6 residents/yr								
Year 1 Salary, benefits, med mal	66,324 x 6	397,944	23,785 x 6	142,710	31,000 x 6	186,000	726,654	
Year 2	66,324 x 12	795,888	21,579 x 12	258,948	31,000 x 12	372,000	1,426,836	
Year 3	66,324 x 18	1,193,832	19,948 x 18	359,064	31,000 x 18	558,000	2,110,896	
Year 4	66,324 x 18	1,193,832	19,948 x 18	359,064	31,000 x 18	558,000	2,110,896	$ 6,375,282
Internal Med: 3 yrs-6 residents/yr								
Year 1 Salary, benefits, med mal	66,324 x 6	397,944	23,785 x 6	142,710	31,000 x 6	186,000	726,654	
Year 2	66,324 x 12	795,888	21,579 x 12	258,948	31,000 x 12	372,000	1,426,836	
Year 3	66,324 x 18	1,193,832	19,948 x 18	359,064	31,000 x 18	558,000	2,110,896	
Year 4	66,324 x 18	1,193,832	19,948 x 18	359,064	31,000 x 18	558,000	2,110,896	$ 6,375,282
Year 1 Total Cost: Add 18 residents							2,179,962	
Year 2 Total Cost: Add 36 residents							4,280,508	
Year 3 Total Cost: Add 54 residents							6,332,688	
Year 4 Total Cost: Add 60 residents							7,024,392	
Total Additional Costs: 4 Years							**$ 19,817,550**	**$ 19,817,550**

ADDENDUM
To

A Recommendations Report to Governor Brian Sandoval
By
The Governor's Medical Education Task Force

July 3, 2014

In working to provide an accurate report, this Addendum modifies and supplements the attached report as follows:

1. Corrections to Title Page

   Members' Titles

   Bill Welch
   Nevada Hospital Association, President/CEO

   David J. Park, DO, FAAFP, FACOFP
   OPTI –West / TUNCOM, Regional Chief Academic Officer

   Member name mispelled

   Mitchell D. Forman, D.O., FACR FACOI, MACP
   Dean & Professor, TUNCOM
   Interim Provost, TUN
   President, Nevada State Medical Association

2. Clarification to Page 2, 4th paragraph
   As written, "A 2006 report by LarsonAllen, an independent Minnesota consulting firm…recommended that the state develop graduate medical education training opportunities…" In 2006 GME programs were functioning. A more accurate representation would be that the state should expand programs.

3. Correction to Page 2, last paragraph
   "In 2017, a third medical school (Roseman University) is slated to open its doors and by 2021, potentially another 60 students would be graduating."

4. Clarification to Page 4, 2nd paragraph
   "The debate on how best to finance the expansion of GME in Nevada will require additional planning. Historically, Medicare and state Medicaid programs have been the primary funders of GME, paying their proportionate share of GME costs. However, in Nevada the primary, and in most cases, the only funding source to help offset the cost of GME is Medicare. Currently, the only state administered GME funding is paid through the public hospital upper payment limit (UPL) GME program for which only the University Medical Center qualifies. In this UPL program, Clark County provides the state share of the funding. No other GME program in Nevada currently receives a

similar payment. Finally, GME training in Nevada is also funded separately by the Veterans Administration (VA) in both the Northern and Southern VA hospitals."

5. Additions and Clarifications to the Recommendations Spreadsheet
   Please see attached spreadsheet (pages 3-6).

6. Additional comments
   Ms. Shendry Thom noted the GME Recommendation Report is a succinct overview and offers the Governor clearly defined solutions to the current shortage of residency slots here in Nevada. In keeping with the Governor's understanding that there is a shortage of all healthcare providers at this time, she respectfully requests consideration of the creation of an advisory council to identify gaps, needs and opportunities for increasing APRNs in Nevada.

GME Task Force Members Final Recommendations June 6, 2014 (revised 7/3/14) The Task Force found consensus with the items highlighted in green.	Number of members commented	Schwenk	Tellez	White	Forman	Hardy	Welch	Penn	Park	Thom	Farrow	Kaufman		
Management/ Accountability provided by:														
Unnamed Governance structure/committee	5						x	x		x	x	x		
Centrally managed by Task Force GME Governance (11 board members) and decentrally executed	3		x			x			x					
Already established NSHE Steering Committee, NSHE Chancellor, NSHE Board of Regents to manage all aspects	2	x		x										
DHHS to manage money from State or other sources until appropriate applications are deemed viable to start a residency	1					x								
Funding acquired through														
State funds (appropriated by the State Legislature, $12M)	7	x	x	x	x			x			x	x		
Federal funds	7	x	x	x	x			x			x	x		
Money leveraging: Inter-governmental transfers, Tobacco settlement funds, fees, fines, and assessments, provider tax, etc.	3		x					x			x			
Unused GME slots for existing successful GME programs with capacity to grow	3		x		x			x						
Private funds	2		X					x						
Funds to be used by/for:														
Expanding programs	10	x	x	x	x	x	x	x		x	x	x		
New Programs	10	x	x		x	x	x	x	x	x	x	x		
All accredited GME-sponsoring institutions	5	x	x	x	x			x						
Consortiums/Collaborative programs	6		x		x	x			x		x	x		
state need--primary care and mental health	6	x			x	x	x				x	x		
state need--other medical specialty gaps (after considering primary needs, student needs)	6	x	x	x	x		x					x		
improve quality of programs	4	x		x	x						x			
Training other healthcare providers (Physician Assts, Nurse Practioners and Nurses)	2			x				x						
Out patient focused entities (Community Health Ctrs/FQHCs)	2					x					x			

GME Task Force Members **Final Recommendations** **June 6, 2014** (revised 7/3/14) **The Task Force found consensus with the items highlighted in green.**	**Number of members commented**	**Schwenk**	**Tellez**	**White**	**Forman**	**Hardy**	**Welch**	**Penn**	**Park**	**Thom**	**Farrow**	**Kaufman**		
incentive eligible heatlh care institutions to create new GME programs wit a one-time grant for start up dollars.	3						x		x			x		
Undergraduate Medical Education (UME)	1			x										
Public Institutions only	1			x										
Hospitals only *	2						x					x		
Teaching Health Centers (same as #18)	1				x									
Criteria upon which to determine if/how funding should be awarded:														
Respectful of CMS, and Residency Allocation Capitations set forth by ACGME and governing boards (critical to maximize the 5 year CAP on growth)	4		x		x		x					x		
Evidence of evaluated clinical experience/volume of patients, commitment and readiness to establish/expand residency training program and demonstrate the financial sustainability of the program being proposed; Existence of Medicare beds, DME, program directors, potential faculty	4	x	x				x					x		
Agree to annual reporting of progress update, financial report, and measurable outcomes of the residency being implemented (i.e. new residents trained, etc.).	4					x	x		x			x		
the availability of hospital partners and clinical and teaching resources	2	x			x									
Applicants must provide a detailed proposal that includes specific start-up costs being requested, estimated time for first residents to be trained, number and specialty of residents to be trained, and a detail proposed operating budget	3	x				x						x		
student demand for the specialty program proposed	1	x												
negotiate funding to hospitals that might include full or partial repayment of start up costs once CME revenue begins	1				x									
the past GME experience of the applicant institutions	1	x												
the economic impact of the graduates anticipated from the expanded/new programs.	1	x												

GME Task Force Members Final Recommendations June 6, 2014 (revised 7/3/14) The Task Force found consensus with the items highlighted in green.	Number of members commented	Schwenk	Tellez	White	Forman	Hardy	Welch	Penn	Park	Thom	Farrow	Kaufman		
Clinical rotations within NV's local, state and federal medical centers and institutions	1			x										
Priority will be given to at least 3 New Residency Programs at new GME hospitals or other clinical sites for start-up funding requests to the extent applications meet the additional requirements	2						x					x		
Priority to requests to expand in Nevada's physician shortage specialties (internal, family, and pediatric medicine, psychiatry, and general surgery).	2						x					x		
GME start up funds coordinated with current and future state-supported UME programs				x										
Application Process														
Advance notice to potential applicants of potential funds, 30 days notice prior to application deadline	2						x					x		
Funding awards that meet or exceed the criteria below will occur within 45 days of the close of the application process.	2						x					x		
Remaining funds follow the same process each year	2						x					x		
Any proposal can not receive more than the lower of the approved amount or the actual costs expended (if subsequent to the application approval, either the estimated cost aren't incurred or CMS later provides funding, previously approved funding must be refunded to the GME Pool).	2						x					x		
Outcomes measures/Quality indicators														
Annual reporting provided by the applicant and governing group including progress update, financial report, and measurable outcomes of the residencies being implemented, satisfaction of partners, sustainability, monies leveraged	7	x		x			x	x		x	x	x		
Retention of doctors and residents	3			x	x					x				
Factors influencing physicians career(school through practice)	1			x										
Continuous data collection on evolvoing workforce to assess changing needs	1			x										

GME Task Force Members Final Recommendations June 6, 2014 (revised 7/3/14) The Task Force found consensus with the items highlighted in green.	Number of members commented	Schwenk	Tellez	White	Forman	Hardy	Welch	Penn	Park	Thom	Farrow	Kaufman		
Other considerations														
Initial start up costs ($3M, see also Mr. Welch's table)	3					x	x					x		
Hospitals already identified as potential GME sites could be encouraged to make due diligence to do GME	1					x								
Protect state funding for future GME funds	2				x	x								
explore how to use Western Interstate Commission for Higher Education (WICHE) to facilitate and enhance GME	1					x								
Provide deep appreciation for the Governor's support in finding solutions to the GME challenges in Nevada	1							x						
Need more exploration and study	1							x						
Emphasize time from availability of $s to the impact on the # of physicians in GME, and then practicing in Nevada, will be several years; so early returns may be low	1							x						
Applicants make at least a 4 year commitment to fund any shortfalls	1			x										
time-line for starting a program is 18-24 months, likely longer	1				x									
GME expansion over UME expansion	1				x									
State funds ($9M to So. NV; $3M to Rurals/No. NV)	1			x										
Approx. 200 NV graduates annually, fewer than 20% do residencies in NV	1			x										
Nearly 1/2 of non-residents are graduates of foreign medical schools, denoting Nevada GME programs are not highly sought after by medical school graduates.	1			x										
A large portion of UNSOM graduates leave to pursue residencies in specialities not offered in NV	1			x										
Limited producion of physicians, low numbers of GME training positions, few GME subspecialities and low retention rates of non-state residenceleads to critical shortages, loss of residents to other states and poor healthcare options.	1			x										
***Mr. Welch clarified he voted for 3 new GME residency hospitals and other clinical sites.**														