Graduate Medical Education Funding

Community Health Center Resources for Residency Training

California Primary Care ASSOCIATION

California Primary Care Association

The California Primary Care Association (CPCA) was formed in 1994 and is the statewide leader and recognized voice representing the interests of California community health centers (CHCs) and their patients. CPCA represents more than 1,300 not-for-profit CHCs and Regional Clinic Associations who provide comprehensive, quality health care services, particularly for low-income, uninsured and underserved Californians, who might otherwise not have access to health care. CPCA provides advocacy, education, and services to lead and position CHCs as key players in the health care delivery system in order to improve the health status of their communities.

California Community Health Centers

CHCs are nonprofit, tax-exempt clinics that are mission driven to minimize the impact of barriers to health and health care access including poverty, lack of health insurance, immigration status, ethnicity, language and culture, disability, homelessness, geographic isolation and other diverse needs. California's CHCs offer a proven delivery model that can serve as a quality benchmark for meeting the needs of California's diverse and disenfranchised populations. As providers for the most vulnerable Californians, CHCs understand that in order to achieve the goal of access to health for all, California cannot rely entirely on incremental expansion of existing publicly funded health insurance programs. Access to healthcare will require expanding and diversifying our physician workforce to meet the needs of California's diverse patient population.

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December, 2019

Community Health Center Residency Road Map

Several CHC Graduate Medical Education (GME) Programs in California have taken advantage of opportunities available through the Health Resources and Services Administration (HRSA) Teaching Health Center Graduate Medical Education (THCGME) Program, Song-Brown Healthcare Workforce Training Program, and CalMedForce Program to sustain, expand, and develop new residency programs. Many other CHCs also continue to explore the potential of developing primary care residency programs and partnerships to grow their workforce.

As a result, CPCA developed the Community Health Center Residency Road Map to offer a series of trainings and resources that achieve the following three goals:

- Develop comprehensive trainings and resources for CHCs desiring to implement or sustain residency training programs or partnerships;
- Increase the number of new CHC residency partnerships and accredited programs to expand primary care GME in California; and
- Strengthen and sustain existing CHC residency partnerships and accredited programs to maximize ongoing efforts that train primary care residents to work with underserved populations in community-based settings and underserved areas.

This program was developed with the generous support of the Northern and Southern California Kaiser Permanente Community Health Programs and in partnership with Wipfli, LLP. Through this work, CPCA created a number of different toolkits and offered several in-person meetings whose presentations were converted to webcasts.

Community Health Center Residency Road Map Resources

ADDITIONAL RESOURCES

- Pathways to Residency: Community Health Center Models for Graduate Medical Education
- Preparing for Accreditation: Community Health Center as Sponsoring Institutions
- Self-Assessment and Action Plan: Community Health Center Sponsoring Institution and Residency Program

TRAINING WEBCASTS

- Training Physician Residents in Community Health Centers
- ACGME Accreditation: Community Health Centers as Sponsoring Institutions
- Cultivating Community-Based Graduate Medical Education

ALL MATERIALS developed through the Community Health Center Residency Road Map program can be accessed at www.cpca.org/residency.

About this Resource

Graduate Medical Education Funding

Community Health Center Resources for Residency Training

This resource was developed as part of the Community Health Center Residency Road Map to outline the variety of GME funding resources available for CHCs according to the four commonly used residency training models – CHC as a sponsoring institution, consortium partner, continuity clinic, and rotation site. Availability of federal and state grant-funding programs is subject to change depending on congressional and legislative action in addition to varying priorities of philanthropic organizations. This resource is intended to give a snap shot of the GME funding available at the time in which this resource was produced.

Cost of Graduate Medical Education

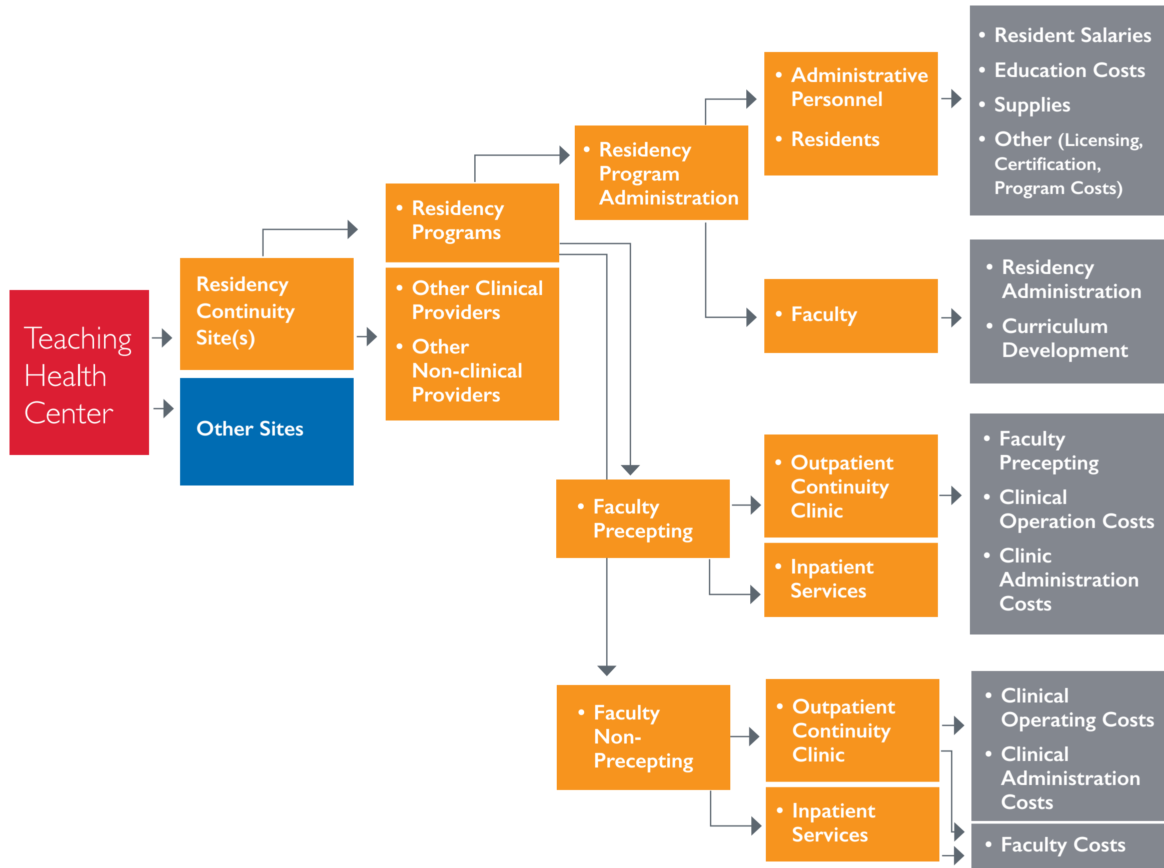
Developing, sustaining, and expanding GME programs require a significant investment on behalf of the training institution and its affiliated sites. *The Cost of Residency Training in Teaching Health Centers* calculated that in fiscal year 2017 the estimated median net cost of training a physician resident within a THCGME was $157,602 (Regenstein, Nocella, Jewers, & Mullan, 2016). Some programs have higher and lower expenses depending on their program characteristics, educational partners, financial arrangements, training locations, GME model, etc. The diagram on the following page builds off the *Teaching Health Center Costing Framework* developed by the Health Resources and Services Administration (HRSA) in their *2019 THCGME Direct and Indirect Training Expense Report to Congress* (Health Resources and Services Administration, 2019). In this revised version, expenses for the residency training are divided into three core components, which include residency program administration, faculty precepting, and faculty non-precepting. Several other costs contribute to the significant investment needed to train physician residents through multi-year residency programs.

These expenses can be better understood through a recently published report, *Cost Estimates for Training Residents in a Teaching Health Center* (Health Resources and Services Administration, 2019).

It shows that:

- Resident salary and fringe benefits account for 26 percent of a THCGME expenses;
- Faculty salary and fringe benefits, along with precepting contracts, related to residency teaching and administration, precepting outpatient and inpatient service, and clinic administration time equate to approximately 30 perecent of THCGME costs. Residency teaching and administration includes all revenues and expenses related to teaching that includes didactics, evaluations, lecture preparation, mentoring, committee work, etc.;
- Clinical administrative and operational expenses, which encompass with all inpatient and outpatient operational costs dedicated to resident patient visits make up 19 percent of THCGME expenses;
- Additional educational expenses, which include residency program personnel costs, occupancy, and overhead amount to 17 percent of THCGME costs; and
- In-kind expenses, which are consumed by GME partners and precepting contracts equate to nine percent of THCGME expenses.

Teaching Health Center Expenses



Community Health Center Graduate Medical Education Funding Opportunities

Active federal and state efforts to expand GME funding have revolutionized the training landscape and incentivized the development of residency programs that are located in areas of unmet need, serve underserved populations, and train diverse physician cohorts. Large opportunities not seen in previous years are currently available to sustain, expand, and develop new residency programs. The table below outlines what opportunities are available for CHCs that are ACGME-accredited sponsoring institutions, consortium partners, continuity clinics, and rotation sites.

AVAILABILITY OF RESIDENCY FUNDING ACCORDING TO GME MODEL

	CHC AS A ACGME-ACCREDITED SPONSORING INSTITUTION	CHC AS A MEMBER OF A CONSORTIUM	CHC AS A CONTINUITY CLINIC FOR EXTERNALLY SPONSORED GME PROGRAM	CHC AS A ROTATION OR ELECTIVE SITE FOR EXTERNALLY SPONSORED GME PROGRAM
FEDERAL FUNDING				
HRSA THCGME Program	X	X		
Centers for Medicare and Medicaid Services (CMS) Direct and Indirect GME	Hospital may pay teaching costs if CHCs do not claim Medicare GME funding. CHCs are only able to access direct Medicare GME funding if the hospital waives the right to claim direct GME costs.	Hospital may pay cost of education and mission support to consortium utilizing CMS funds.	Hospital may pay cost of education and mission support via a Community Benefit Grant to CHC utilizing CMS funds. CHC is eligible to claim Direct GME funding provided the hospital waives its right to do so.	Hospital may pay any teaching costs.
Veterans Administration	X			
STATE FUNDING				
Song-Brown Program	X			
CalMedForce Program	X			
Prospective Payment System Reimbursement	X*	X	X	X
LOCAL FUNDING				
Institutional Direct Support from Operations	X	X	X	X
Private Foundations	X	X	X	X
Partnering Universities	X	X	X	X
Health Plans	X	X	X	X

**FQHC and RHC residency programs that are ACGME accredited and federally or state sponsored qualify for CA SPA 18-0032.*

Federal Graduate Medical Education Funding Sources

HRSA Teaching Health Center Graduate Medical Education (THCGME) Program

The THCGME program is administered by the Health Resources and Services Administration (HRSA) and was established by the Affordable Care Act in 2010 to incentivize primary care physician and dental resident training in community-based ambulatory clinics. Since its inception, the THCGME program has trained 880 new primary care physicians and dentists that have graduated and entered the workforce. This program aims to increase health care quality and access to providers that prioritize care for underserved communities and vulnerable populations. In academic year 2018-2019, the THCGME Program supported the training of 728 residents in 56 primary care residency programs across 23 states.

ELIGIBLE APPLICANTS

Qualified teaching health centers support residency training in the following specialties: family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

Eligible community-based ambulatory settings include, but are not limited to:

- Federally-qualified health centers (FQHCs) and FQHC Look-Alikes,
- Community mental health centers,
- Rural health clinics (RHCs) and health centers operated by the Indian Health Service or an Indian tribe or tribal organization,
- Entities receiving funds under Title X of the Public Health Service (PHS) Act, and
- Consortiums where one of the above listed entities holds a substantial role.

Payments are made for direct and indirect expenses to qualified teaching health centers that are listed as sponsoring institutions by the relevant accrediting body for expansion of existing, or establishing of new approved, graduate residency training programs.

AVAILABLE FUNDING

The THCGME Program was established in 2010 to support the expansion of primary care medical and dental residency training in community-based ambulatory settings. The initial 5-year, $230 million THCGME appropriation ended on September 30, 2015, and the Medicare Access and CHIP Reauthorization Act of 2015 provided $60 million in THCGME program funding for each of fiscal years (FYs) 2016 and 2017. The Bipartisan Budget Act of 2018 appropriated $126.5 million for the THCGME program for each of FYs 2018 and 2019. The last set of funds available through this appropriation was granted in Fall 2019 to existing THCGME grantees and approximately five new THCs across the country, two whom are CHCs in California. Funding was prioritized for residency programs located in underserved and/or rural areas.

THCGME funding expired September 2019 and a Continuing Resolution was passed to allocate short-term funding. Large advocacy efforts are in play to once again secure long-term THCGME funding.

FOR MORE INFORMATION: Visit https://bhw.hrsa.gov/grants/medicine/thcgme.

Centers for Medicare and Medicaid Services

DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION FUNDING

Centers for Medicare and Medicaid Services (CMS) is the single largest financier of Graduate Medical Education, beginning in 1965 with the passage of Medicare. At that time, it was deemed appropriate for Medicare to pay "its fair share" of GME direct expenses and so the methodology of Direct GME was born. The Direct component of GME was designed to pay for Medicare's share of residents' salaries, benefits, supervising physician compensation, certain administrative expenses, and malpractice.

In 1982, Indirect Medical Education (IME) was authorized and subsequently implemented in 1984 because of the recognition that hospitals were incurring additional costs by educating interns and residents. With the passage of Diagnosis Related Group (DRG) payments, enhanced resident supervision requirements, and the implementation of managed care models, increased costs due to excess utilization is no longer an extensive issue, especially for the primary care residency programs.

In 1992, the Council on Graduate Medical Education (COGME) published its Third Report where it spoke to an oversupply of physicians. Based on COGME's recommendations and a desire to balance the federal budget, the Balanced Budget Act of 1997 (BBA97) was authorized. BBA97 brought dramatic change to the world of GME finance, including the creation of GME "caps". This legislation capped hospitals at their 1996 resident full time equivalents in their cost report. There are limited ways for a hospital to increase its cap. The primary way is for hospitals with a cap of "0" to have a new residency program begin at their facility. These "GME Naïve" hospitals are able to establish a cap in their fifth year. This is important to CHCs as partnering with a GME Naïve hospital will allow for Medicare reimbursement for Medicare's share of the allowable costs and time of the residents in a new program. CHCs will want to partner with a GME Naïve hospital whenever possible. The exception to this is when a HRSA THCGME funded program begins at a GME Naïve hospital as doing so can establish the hospital's Direct GME payment at $0 and will trigger the establishment of the hospital's GME cap.

CHC ENGAGEMENT WITH CMS FUNDING

When CHCs partner with a hospital that is being paid Continuing Medical Education (CME) Direct GME and IME, it is important for the hospital to pay the CHC the costs of teaching. Doing so benefits the hospital as part of its DGME reimbursement calculation while mitigating the financial risk of the CHC. The parties must be diligent with contracting for payment that is always at Fair Market Value. Because the impact of a training program on a CHC is usually greater than that which the cost of training payment covers, hospitals may provide a Community Benefit Grant to the CHC. The total of the teaching payment and the Community Benefit Grant may be greater than the amount the hospital receives in Direct and Indirect GME payments.

FQHCs and RHCs can also receive the Direct portion of CMS GME funding. Title 42, Code of Federal Regulations § 413.75 provides for FQHCs or RHCs to receive direct graduate medical education payments when the RHC or FQHC incurs "all or substantially all" of the costs of the training program in the non-hospital setting. For this to occur, the costs of the residents' salaries, benefits, travel and lodging (if appropriate) and teaching faculty salaries and benefits must not be claimed by the hospital for the purposes of obtaining Direct GME reimbursement. FQHC/RHC facility overhead costs may also be allocated to Graduate Medical Education. Additionally, the costs, which must be tracked in a separate cost center, are not allowable if the hospital pays the FQHC or RHC for those costs.

Payment to the FQHC/RHC for Direct GME is equal to the RHC's or FQHC's allowable direct graduate medical education costs multiplied by Medicare's share – which is the RHC/FQHC's percentage of Medicare visits to total visits. Because this percentage is often quite low, product of this calculation is relatively small and the decision is then usually made to have the hospital claim the costs and receive the Direct GME reimbursement rather than the FQHC/RHC. Should the hospital be projected not to receive any CMS Direct funding for the residents, then the FQHC should claim those teaching costs.

FQHCs and RHCs cannot received Indirect GME reimbursement. This is only something available to hospitals.

Veterans Administration

GRADUATE MEDICAL EDUCATION FUNDING

The Veterans Administration (VA) has a long-standing role in supporting and directly training medical residents through partnerships with non-VA hospitals and medical schools. Historically, they paid for resident training costs during the residents' time in a VA facility, but did not cover costs when the resident was in a non-VA facility. In 2015, greater efforts were made through the Veterans Access, Choice, and Accountability Act of 2014 (VACAA or the Choice Act) to create 1,500 new residency slots in primary care, mental health, and other specialties the VA Secretary deemed necessary. Their focus was concentrated in VA facilities that had little to no experience in training physician residents, communities with high concentrations of Veterans, and sites with provider shortages. As they continued to work towards this objective, new legislation was passed in 2018 that is helping them meet their goal and increasing opportunities for CHCs to partner with the VA for GME.

On June 6, 2018, the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the VA MISSION Act of 2018 (S. 2372; P.L. 115-182; H.Rept. 115-671), was signed into law. It was enacted on September 29, 2018 and calls for the development of a pilot program that requires the VA to establish GME programs at community-based facilities, including those operated by a Federally Qualified Health Center, the Indian Health Service or an Indian tribe. Under this program, the VA would pay for costs associated with a developing a program and for residents' time when they are not training at VA facilities.

In March 2019, the Department of Veterans Affairs Office of Academic Affiliations put out a Request for Proposals (RFP) for VACAA resident physician funding to supplement base resident physician GME positions. The funding is targeted at ACGME-accredited primary care (including geriatrics) and mental health residency programs. Priority is given to new GME sites or those in health professional shortage areas, rural locations, or in a program with significant delays in Veteran access to care. Facilities applying for GME position funding are required to have an affiliation with an accredited physician resident training program. Residency programs must be in good standing with the appropriate accrediting body or well into the process of accreditation. Accreditation by the American Osteopathic Association (AOA) or Accreditation Council for Graduate Medical Education (ACGME) must be documented in the proposals.

FOR MORE INFORMATION

Go to www.va.gov/oaa/ and review their RFP at www.va.gov/OAA/docs/Request_for_Proposals_VACAA_Physician_Resident_Positions_Grant_for_Graduate_Medical_Education_GME_Round_6.pdf.

If you're interested in partnering with VA in GME, call OAA's VA GME Helpline at 1-202-461-9490 or email them at gmehelp@va.gov.

State Graduate Medical Education Funding Sources

Song-Brown Healthcare Workforce Training Programs

PRIMARY CARE RESIDENCY (PCR) PROGRAMS

The Song-Brown program funds residency programs that train primary care health professionals to provide health care in California's medically underserved areas.

Competitive proposals will demonstrate a commitment to Song-Brown goals and demonstrated success in meeting the three statutory priorities as follows:

- Attracting and admitting under-represented minorities and those from underserved communities
- Training residents in underserved areas
- Placing graduates in underserved area

Grant awards from this program have sustained 557 first-year PCR positions in existing PCR programs and developed 72 first-year positions in newly accredited PCR programs as of December 2018 (State of California, 2019).

ELIGIBLE APPLICANTS, AVAILABLE FUNDING, AND AWARD CATEGORIES

Prior to receiving Song-Brown funds, a training program awardee shall demonstrate that it:

- Is accredited by the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee, or the American Osteopathic Association (AOA) Council on Postdoctoral Training.
- Has programs or departments that recognize Family Medicine, Internal Medicine, Obstetrics and Gynecology, or Pediatrics as major independent specialties.

2019-2020 FUNDING CATEGORIES

AWARD CATEGORY	ELIGIBLE PROGRAMS	AWARD LEVEL	MAXIMUM SLOTS	BUDGET TYPE
Existing Slots	Primary Care Residency (PCR) programs that will enroll one class by 7/1/20	$125,000 per first year slot (three year allocation)	Five	Capitation
Teaching Health Center (THC) Existing Slots	THC programs that will enroll one class by 7/1/20	$170,000 per first year slot (one year allocation)	N/A	Itemized Budget
Expansion Slots	PCR programs that have a permanent increase in categorical PCR positions	$300,000 per first year categorical slot (three year allocation)	Three	Capitation
New PCR Programs	PCR programs that receive accreditation after 7/1/16	Up to $800,000 per program (one year allocation)	N/A	Itemized Budget

INITIATING AN APPLICATION

To apply, a CHC must complete an electronic application and provide all necessary information to OSHPD.

FOR MORE INFORMATION: Visit https://oshpd.ca.gov/loans-scholarships-grants/grants/song-brown/#PCR for additional information and the electronic application.

CalMedForce Program

PRIMARY CARE AND EMERGENCY MEDICINE RESIDENCY PROGRAMS

The CalMedForce Program is dedicated to increasing the number of physicians in California by sustaining and expanding primary care and emergency medicine residency programs. CalMedForce receives funding through the voter-approved California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56). All accredited residency programs in the state meeting the guidelines set forth in Proposition 56 are eligible to apply for funding through the CalMedForce Program. In its inaugural cycle, the CalMedForce Program supported the sustainability, expansion, and development of 156 residency positions across the state (Physicians for a Healthy California, 2019).

Eligible Applicants

Eligible residency programs include new residency programs and existing residency programs that may want to apply for support of either expanded and/or existing residency positions.

In order to be eligible to receive funding, a training program must meet the criteria noted below at the time of application:

- Located in California
- Allopathic or Osteopathic
- Primary care (family medicine, internal medicine, obstetrics/gynecology, and/or pediatrics) or emergency medicine
- Accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) Council on Postdoctoral Training
- Serving medically underserved areas and populations

Available Funding

The following funding allocation guidelines were recommended by the Advisory Council and approved by the Board for the application cycle 2019-2020:

- Family Medicine – $9,500,000
- Internal Medicine – $7,125,000
- Obstetrics/Gynecology – $7,125,000
- Pediatrics – $7,125,000
- Emergency Medicine – $7,125,000

The maximum number of residency positions that may be requested for funding is five per program, inclusive of existing, new and expanded positions. Funding per resident slot is dependent on the type of program. For example, existing programs may receive $50,000 per resident per year, expanding programs may receive $60,000 per resident per year, and new programs shall receive $75,000 per resident per year. Funding is approximate and will be disbursed based on scoring criteria. Applications will be evaluated and ranked within their respective specialty.

INITIATING AN APPLICATION

Each applicant must create an individual account with a username and password for each online application. Organizations that applied in previous application cycles may reuse their credentials.

FOR MORE INFORMATION

If you have any technical questions, please email CalMedForce@phcdocs.org. For additional information and to apply for the 2019-2020 cycle, visit www.phcdocs.org/Programs/CalMedForce.

Medi-Cal Prospective Payment System (PPS) Reimbursement

STATE PLAN AMENDMENT 18-0032

The California State Plan Amendment (SPA) 18-0032 was submitted to the Centers for Medicare and Medicaid Services (CMS) on June 29, 2018 and approved on September 21, 2018 (California Department of Health Care Services, 2019). SPA 18-0032 authorizes reimbursement under the PPS methodology for services performed by qualifying Teaching Health Center Graduate Medical Education primary care resident physicians at participating FQHCs and RHCs.

FOR MORE INFORMATION

You can review the approved SPA 18-0032 at www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA18-0032ApvPkg.pdf and California Medi-Cal Provider Manual at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/rural_o01o03.doc.

Eligibility

In order to be eligible for PPS reimbursement under SPA 18-0032, all the conditions noted below must be met:

- The residency program must be federally or state-sponsored by the HRSA THCGME Program, Song-Brown Healthcare Workforce Training Program, and/or CalMedForce Program.
- The THC program is required to be accredited by the American Council of Graduate Medical Education (ACGME).
- The teaching physician must have the primary medical responsibility for patients cared for by the residents, and ensure the care provided is reasonable and necessary.
- The teaching physician must not supervise more than four residents at any given time.
- Residents with less than six months experience in a THC program must have the teaching physician physically present for critical or key portions of the services.
- Teaching physicians must review the patient health record and document teaching physician's participation in direction of the services.

REQUEST FOR SCOPE OF SERVICE RATE CHANGE

Under California law, a FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in scope of services provided by the FQHC or RHC (State of California, 2019). Included in the change in scope of service definition is "indirect medical education adjustments and direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents."

Community Health Centers may file a change in scope of service request to add costs associated with residency training and take advantage of PPS reimbursements offered through SPA 18-0032. The effective date of this SPA is April 1, 2018. Change in scope of service requests must be coordinated with the Department of Health Care Services (DHCS).

FOR MORE INFORMATION

You can go to the Audits and Investigations webpage of DHCS: www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx. For assistance and questions please contact Audit Review and Analysis at (916) 650-6696 or Clinics@dhcs.ca.gov.

PHYSICIAN LICENSURE REQUIRED FOR MEDI-CAL PPS REIMBURSEMENT

California law allows FQHCs to bill the Medi-Cal Program for a "visit" that includes a face-to-face encounter between an FQHC or RHC patient and a "physician" (State of California, 2019). With the implementation of SPA 18-0032, the Medi-Cal Provider Manual, Part 2 – Clinics and Hospitals (CAH) – Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) defines "physicians" as:

- "A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license
  - A primary care resident physician, in a HRSA or a State sponsored Teaching Health Center Graduate Medical Education (THCGME) Program, supervised by a designated teaching physician.
- A doctor of podiatry authorized to practice pediatric medicine by the State and who is acting within the scope of his/her license.
- A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license.
- A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license.
- A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license." (California Department of Health Care Services, 2019)

CURRENT PHYSICIAN LICENSING PROCESS

Currently, physician residents who completed their medical school training in the United States or Canada must complete 12 continuous months of training in a single program to qualify for an unrestricted physician's and surgeon's license. International medical graduates (IMG), however, must complete 24 months of training to be eligible for licensure. Currently, the Medical Board of California does not issue a training license for domestic and Canadian physician residents. IMGs who wish to participate in postgraduate training and are not eligible for licensure must apply to the Medical Board of California for a Postgraduate Authorization Training Letter (PTAL).

FOR MORE INFORMATION

Visit the Medical Board of California's Physicians and Surgeons website: www.mbc.ca.gov/Applicants/Physicians_and_Surgeons/.

IMPORTANT 2020 CHANGES TO PHYSICIAN POSTGRADUATE TRAINING AND LICENSING REQUIREMENTS

The Medical Board of California is implementing changes to postgraduate training requirements on January 1, 2020. Senate Bill 798 (2017) changes the current minimum requirements of postgraduate training on January 1, 2020 to require 36 months of postgraduate training in a Board-approved program to receive an unrestricted license. This change is applicable to both domestically and internationally trained medical graduates. Further, a Postgraduate Training License (PTL) will be required for all residents participating in an ACGME accredited postgraduate training program in California in order to practice medicine as part of their training program. A PTL must be obtained within 180 days after enrollment in the program and will not be required to be renewed.

FOR MORE INFORMATION

Visit the Medical Board of California website: www.mbc.ca.gov/Licensees/2020_Changes.aspx.

FQHC AND RHC SPONSORING INSTITUTIONS – ACGME ACCREDITED AND HRSA/STATE FUNDED RESIDENCY PROGRAMS

CHCs that are accredited as an ACGME-accredited Sponsoring Institution in their organization qualify under SPA 18-0032 for reimbursement of services provided by physician residents. In order to bill for these services, a CHC has the option to seek a change in scope of service request (CSOSR) to include the cost of resident training into their PPS rate. Once the scope of service rate change is completed alongside the Department of Health Care Services, a CHC should consult with their legal counsel to verify that they are in compliance with Medi-Cal billing requirements.

ACGME–Accredited FQHC/RHC Sponsoring Institutions with HRSA or State Funding *(until December 31, 2019)*

Supervision of Physician Resident by Teaching Physician

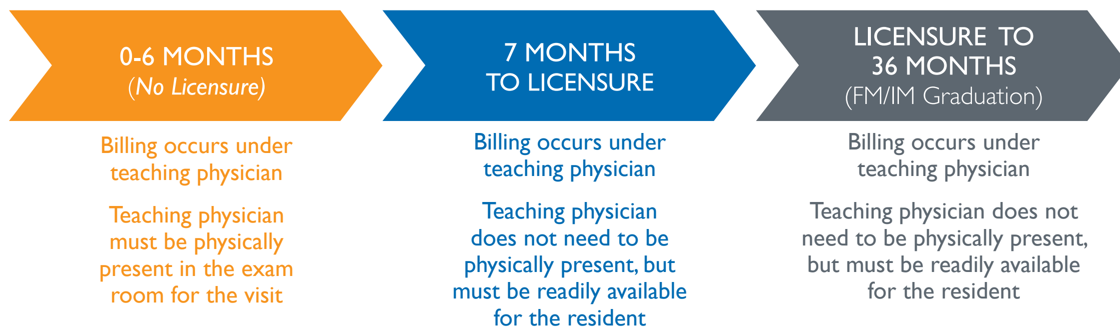
Taking into account the current licensing time frame, there are important differences in supervision that CHCs must take into account as a resident progresses through their residency program. When a resident enters their GME program and has six months or less of postgraduate training, the teaching physician must be physically present in the exam room for the visit. Patient visits involving unlicensed or licensed residents with at least seven months of residency training do not require the teaching physician to be physically present in the exam room, but do require the teaching physician to be readily available to assist a resident.

Billing for Patient Visits Involving Physician Resident

Billing for patient visits involving a physician resident must always occur under the teaching physician associated with the FQHC or RHC sponsoring institution. This must occur regardless of whether the physician resident is licensed or unlicensed and he or she has between zero to thirty-six months of training.

Until December 31, 2019 – Supervision and Billing Practices for Physician Residents in ACGME–Accredited FQHC/RHC Sponsoring Institutions with HRSA or State Funding.

Resident Supervision and Billing Time Frame



FQHC AND RHC SPONSORING INSTITUTIONS – ACGME ACCREDITED AND HRSA/STATE FUNDED RESIDENCY PROGRAMS

ACGME–Accredited FQHC/RHC Sponsoring Institutions with HRSA or State Funding *(starting January 1, 2020)*

Once the physician licensing changes created by SB 798 go into effect on January 1, 2020, physician residents will obtain a Postgraduate Training License (PTL) for their first 36 months of postgraduate training and be eligible for an unrestricted license after 36 months of postgraduate training. Despite the licensing changes, the Medi-Cal PPS billing process will remain relatively the same given the billing requirements listed under SPA 18-0032.

Supervision of Physician Resident by Teaching Physician

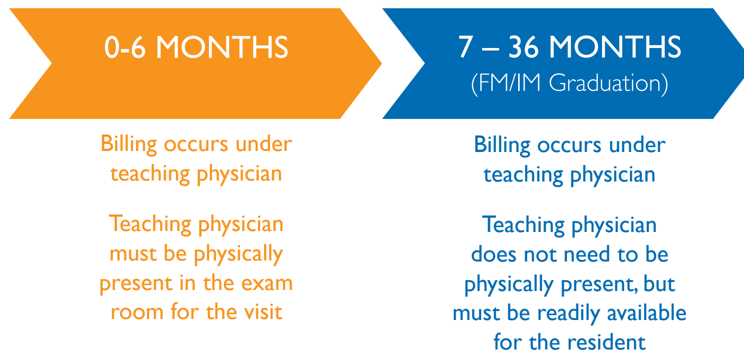
When a resident enters their GME program and has six months or less of postgraduate training, the teaching physician must be physically present in the exam room for the visit. Between the time that a resident has seven to thirty–six months, the teaching physician does not need to be physically present, but must be readily available to assist the resident at any time.

Billing for Patient Visits Involving Physician Resident

Billing for patient visits involving a physician resident with a PTL must always occur under the teaching physician associated with the FQHC or RHC sponsoring institution. This must occur between zero to 36 months of a physician resident's training.

Starting January 1, 2020 – Supervision and Billing Practices for Physician Residents in ACGME–Accredited FQHC/RHC Sponsoring Institutions with HRSA or State Funding.

Resident Supervision and Billing Time Frame



CHC CONSORTIUM PARTNERS, CONTINUITY CLINIC AND ROTATION SITES – NOT ACGME-ACCREDITED OR HRSA/STATE SPONSORED

Over 30 CHCs in California partner with a hospital and/or academic institution to provide community-based ambulatory training to physician residents as a continuity clinic or rotation site. In this model, the CHC does not directly hold the ACGME-accreditation, is not responsible for the Sponsoring Institution accreditation, and is not a direct recipient of a HRSA, Song-Brown, or CalMedForce Program grant. As a result, SPA 18-0032 does not apply to CHC continuity clinic and rotation sites. Therefore, CHCs that serve as a continuity or training site for an external residency program must follow the physician billing requirements put forth by the California Medi-Cal Provider Manual and the California Welfare Institutions Code.

CHC Continuity Clinics or Rotation Sites *(until December 31, 2019)*

Supervision of Physician Resident by Teaching Physician

Patient visits involving unlicensed physician residents must include the physical presence of the teaching physician in the exam room. State regulations do not clearly outline supervisory practices for teaching physicians that precept licensed residents during a patient visit.

Billing for Patient Visits Involving Physician Resident

Patient visits involving unlicensed physician residents must be billed under the teaching physician. The Medi-Cal Provider Manual and WIC indicates that billing can occur for a physician that is licensed and working within their scope.

CHC Continuity Clinics or Rotation Sites *(starting January 1, 2020)*

Supervision and Billing of Patient Visits Involving Physician Resident

The physician licensing changes that will go into effect in 2020 may affect how CHCs that serve as continuity or rotation training sites bill for services involving a physician resident. For these reasons, CPCA is currently working with California state departments to understand what impact these licensing changes will have on health center supervision and billing practices.

Local Graduate Medical Education Funding Sources

Direct Institutional Support

CHCs invest heavily in the development of their own ACGME-accredited Sponsoring Institution or partnership with an academic or hospital-based residency program. Often times that investment comes in the form of human capital, but many additional expenses are acquired along the way that require CHCs to invest in their program or program. Certain funding grants are restricted to funding direct GME costs (i.e. resident stipends, faculty salaries, administrative costs) and not indirect GME costs (i.e. additional testing done by residents in training or reduced clinic productivity). As a result, CHCs often help close the funding gap by using internal funds.

Private Foundations

Some organizations have received support from private funders to start their residency program and/or pay for operational expenses. CHCs often seek these opportunities in their local area, which vary depending on each region's priorities. CHCs seeking such funding will benefit by having a concrete "ask" and demonstrating plans to program sustainability. It is helpful to provide the foundation with a sense of "return on investment" and economic impact of their support.

Health Plans

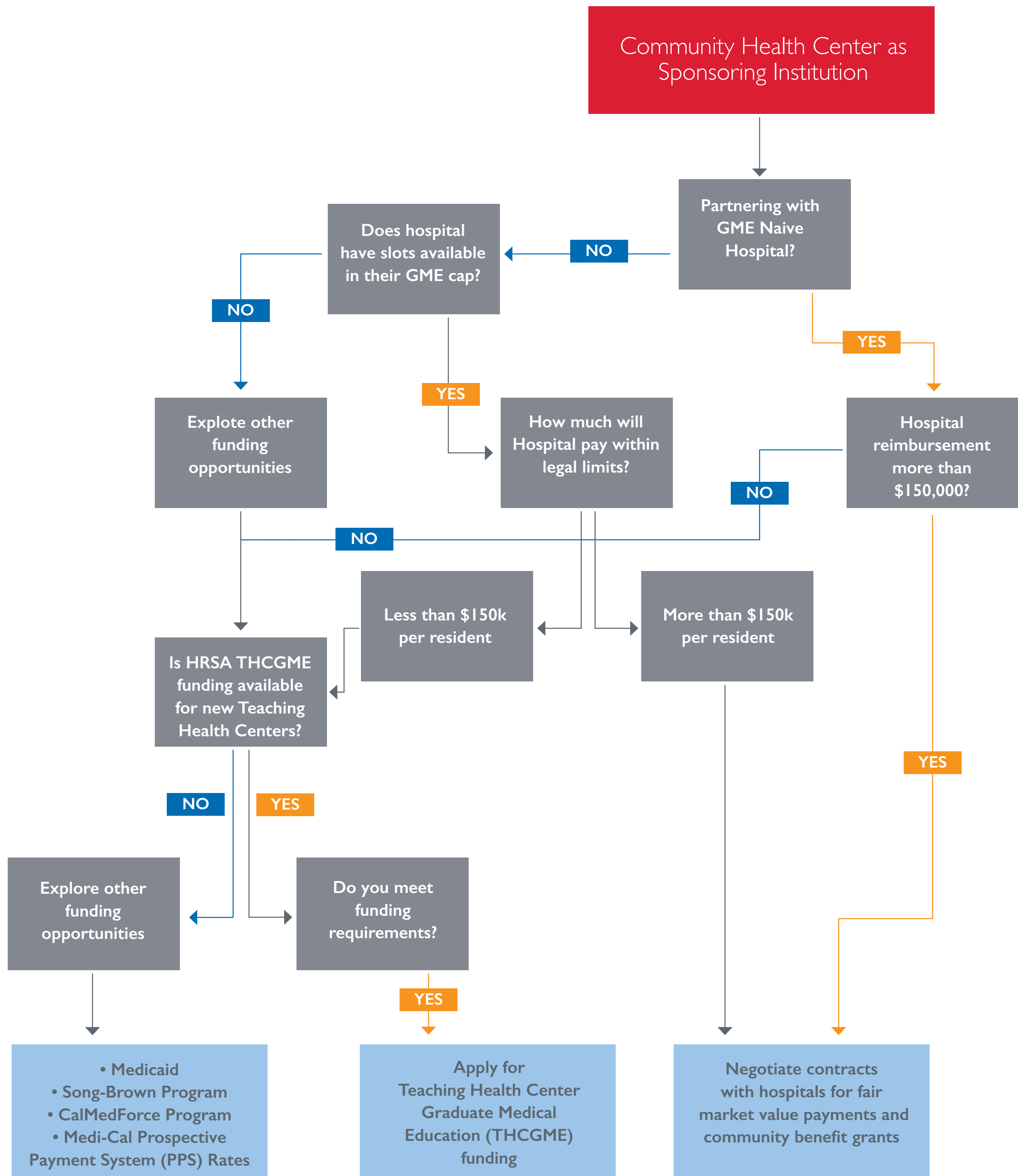
In recent years, some Medi-Cal managed care organizations in the state have made significant investments in the planning and/or ongoing operations of primary care residency programs. Any organization considering a new program and any organization that is facing operational deficits should meet with their local initiative representatives to determine if there is financial support available. Lead time of at least six months needs to be given from the time of the initial ask to a possible decision.

Partnering Universities and Hospitals

CHCs that partner with hospitals and academic institutions can negotiate and request funds that support quality training of physician residents in CHC continuity training sites. This process depends on a health center's relationship with their partners and how the negotiation is made. CHCs that are developing a GME relationship with an external party may request a planning grant to explore the potential of GME training in CHCs. Other CHCs have received ongoing support because their partners recognize the additional responsibilities carried out by the CHC in hosting residents and training them towards independent practice. The key to success if building a relationship over time before making an ask.

Funding Decision Tree

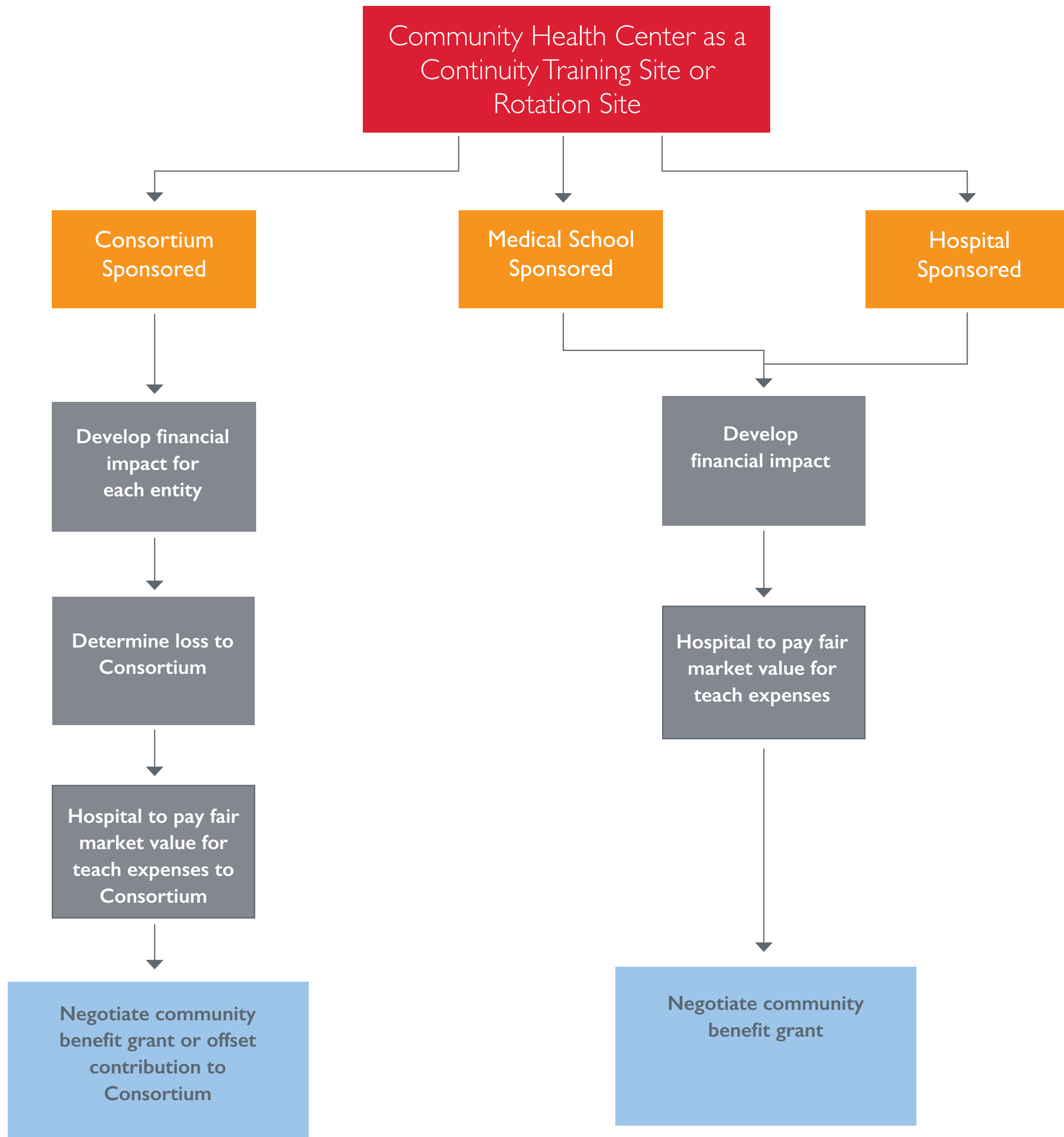
Community Health Center as Sponsoring Institution



Developed by: Wipfli LLP

Funding Decision Tree

Community Health Center as a Consortium Partner, Continuity Training Site, or Rotation Site



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California
Primary Care
ASSOCIATION

www.cpca.org

1231 I Street, Suite 400
Sacramento, CA 95814

(916) 440-8170