

## RURAL GRADUATE MEDICAL EDUCATION INNOVATION

**(Note: This backgrounder is a placeholder as the bill will need to be reintroduced and will have a new bill number in the 116<sup>th</sup> Congress.)**

Support the *Rural Physician Workforce Production Act of 2018*, introduced by Senator Cory Gardner (R-CO) (S. 3014, in the 115<sup>th</sup> Congress.) The bill is backed by the GME-Initiative, Council of Academic Family Medicine, American Academy of Family Physicians, National Rural Health Association, American College of Osteopathic Family Physicians and the American Association of Colleges of Osteopathic Medicine. We are working to have it reintroduced in the new, 116<sup>th</sup> Congress.

### Background:

The geographic maldistribution of primary care physicians is a problem in the United States. Rural areas particularly lack access to primary care physicians and other shortage specialties compared to urban and suburban areas. One of the most promising solutions to this problem is increasing physician training in rural areas. Congress has made some progress in this area (e.g. the Teaching Health Center Graduate Medical Education (GME) program), but vastly more is needed to support rural training.

Medicare remains the dominant driver of GME policy in the United States, as it accounts for two-thirds of public funding for residency training (roughly \$10 billion out of some \$15 billion altogether per year). Medicare is the only stable national source of GME funding, in comparison to other grant funding such as HRSA-run programs and highly variable Medicaid GME funding. Rural hospitals operate on very narrow margins so cannot commit to ongoing residency training costs without a stable, predictable source of funding. The last major revision to Medicare GME policies took place over 20 years ago, in the *Balanced Budget Act of 1997* (BBA). The BBA placed upper limitations (known as “caps”) on institutions sponsoring residency training for the first time. Although Congress also provided incentives for rural training in the BBA and in subsequent legislation, the Centers for Medicare & Medicaid Services (CMS) has implemented Medicare GME policies in ways that arguably run counter to Congressional intent to encourage maximum growth in rural training.

The Government Accountability Office (GAO) recently released a study on physician workforce,<sup>1</sup> stating that “use of federal efforts intended to increase GME training in rural areas was often limited, and officials reported challenges. In addition to the general challenges associated with offering GME training in rural areas, CMS officials reported a number of challenges with using Medicare funding to support rural GME training.” The challenges identified by GAO are outlined below along with solutions proposed in the bill.

1. **Financing:** The bill enhances hospitals’ ability to pay for rural residency training by establishing in Medicare a “National Per Resident Payment” (NPRP), to replace Medicare GME (both DME and IME) payments under existing law. The NPRP has the following features:

- The NPRP is optional. A hospital can choose between it and traditional GME payment.
- The NPRP is available to finance rural training in any medical specialty.
- The NPRP is available for full-time equivalent (FTE) training time in a rural location for any duration longer than eight weeks. Additionally, the NPRP is available for the entire length of



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training for those positions that are at least 50% rural (e.g. rural training tracks or “RTT”).

- The NPRP is equivalent to the national 85<sup>th</sup> percentile of payment amounts in both direct GME and indirect medical education (IME), and is not discounted based on Medicare patient load. In other words, it is specifically calculated to enhance payment to hospitals for rural training positions. This ensures that the hospital has enough funds to cover the higher costs of rural and ambulatory training, which typically are not met under current Medicare reimbursement.
- The NPRP is “budget neutral,” meaning that it will not increase overall federal spending. Any increase in spending through the NPRP would be offset by an equivalent decrease in spending on traditional Medicare GME to hospitals.

2. **Caps.** As described above, the BBA established caps for Medicare GME for participating institutions, which were set at 1996 levels and with few exceptions have not been raised since. The bill would allow growth in rural training to occur freely, without regard to caps set by CMS. Specifically, teaching hospitals would be authorized an unlimited number of FTEs for RTTs, without regard to their CMS cap. In addition, FTE time spent rotating through rural locations for a minimum of 8 weeks would not count toward a teaching hospital’s cap. We do not expect over-proliferation as rural areas are inherently limited by lack of infrastructure such as faculty and interested residents to develop new, large programs.

3. **Payment to Critical Access Hospitals (CAH) and Sole Community Hospitals (SCH).** The bill gives the ability of CAHs (which make up 61% of all rural hospitals) and SCHs, to obtain IME funding, and allows urban hospitals to once again claim training time for residents they send to CAHs. Currently, CAHs are paid based on 101% of their reasonable costs, which does not include IME. Almost all SCHs have no access to IME payments. Leveling GME payment for training in rural hospitals will incentivize urban residency sponsors to train more residents in rural locations.

## **Frequently Asked Questions**

### **Can urban hospitals benefit from this new payment?**

Yes. First, they can expand their RTT sites and receive payment for the full training time of those programs, regardless of their cap. Second, as they send residents for training in rural areas and elect the NPRP, those residents will free up space under their cap for which they can count additional FTEs to fill. Thus, growth above the institution’s cap is targeted to rural training, rather than being indiscriminately lifted. This training could offer educational experiences not offered in urban settings for many specialties.

### **Why would rural and ambulatory training cost more than traditional training?**

According to the GAO,<sup>i</sup> “GME training in outpatient settings, such as community-based clinics, is considered less efficient and more expensive than in inpatient hospital settings.” In addition, “rural training sites may incur higher costs because their training may have to utilize multiple training sites—such as community hospitals or rural health clinics—to meet accreditation requirements for resident rotations and patient case-mix. The added administrative work of coordinating with other sites to provide these resources can be a challenge.”

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<sup>i</sup> Government Accountability Office, Physician Workforce: Locations and Types of Graduate Training Were Largely Unchanged, and Federal Efforts May Not be Sufficient to Meet Needs, GAO-17-411, May 2017, at 25-26.

<sup>ii</sup> Government Accountability Office, Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding, GAO-18-240, Mar. 2018, at 29-30.