RURAL GRADUATE MEDICAL EDUCATION INNOVATION

Please cosponsor S. 1893, the Rural Physician Workforce Production Act of 2021, a bipartisan bill introduced by Senators Tester (D-MT) and Barrasso (R-WY). It is backed by the GME-Initiative, Council of Academic Family Medicine, American Academy of Family Physicians, National Rural Health Association, American Osteopathic Association, American College of Osteopathic Family Physicians, and the American Association of Colleges of Osteopathic Medicine.

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. The current COVID-19 pandemic has exacerbated the situation and shown light on the increasing need in rural areas for an adequate physician workforce and health care infrastructure. 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 Medicaid GME funding. Rural hospitals operate on narrow margins and cannot commit to ongoing residency training costs without a 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 the BBA and subsequent legislation also provided incentives for rural training, the Centers for Medicare & Medicaid Services (CMS) has implemented Medicare GME policies counter to Congressional intent discouraging maximum growth in rural training.

The Government Accountability Office (GAO) recently released a study[i] on physician workforce, stating that “use of federal efforts intended to increase GME training in rural areas was often limited and challenging. CMS reported difficulties associated with offering GME training in rural areas, as well as using Medicare funding to support rural GME training.” The challenges identified by GAO are outlined below along with solutions proposed in the bill.

Recognizing the problems identified by the GAO, the Council on Graduate Medical Education (COGME) recommends that “CMS and other agencies could create other incentives that permit rural hospitals to establish fair ‘total resident amounts’ for GME funding and decrease the disparities between urban and rural funding.”[ii]

1. **Financing**: The bill enhances hospitals’ ability to pay for rural residency training by establishing in Medicare an “Elective Rural Sustainability Per Resident Payment” (ERS-PRP) to replace current Medicare Direct Medical Education (DME) or direct cost payments under existing law. The ERS-PRP has the following features:

- The ERS-PRP is optional. A hospital can choose between it and traditional GME payment(s).
- The ERS-PRP is available to finance rural training in any medical specialty.
- The ERS-PRP is available for full-time equivalent (FTE) training time in a rural location for any duration longer than eight weeks.
- The ERS-PRP is available for the entire length of training for those positions training greater than 50% in rural locations (e.g., rural training tracks or “RTTs”).

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- A Total Elective Rural Sustainability Amount (TERSA) is tied to national direct education expenses from cost reports (identified in GAO 2018 report[iii] as approximately $151,000 in 2015.) An Urban TERSA is half that figure.
- These payments are not discounted based on Medicare patient load. In other words, it is specifically calculated to enhance payment to hospitals for rural training positions.
- The bill is budget neutral.

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; despite that the number of residents in training has risen by 27%.[iv] Yet the rural maldistribution remains. S. XXX would allow growth in rural training to occur freely, without regard to caps set by CMS. Specifically, teaching hospitals are authorized an unlimited number of FTEs for RTTs, without regard to their 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, staff, and resident selection to develop new 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 the ERS-PRP if they host a training program, rather than be limited by current Medicare GME funding rules, and allows urban hospitals to claim training time once again for residents they send to CAHs. This latter concern has been addressed in a recent CMS regulation, but not in statute.

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 ERS-PRP, 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,[v] "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 also be a challenge.

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[i] Government Accountability Office, Physician Workforce: Location 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
[ii] Council on Graduate Medical Education. Investing in a Health Workforce that Meets Rural Needs. Feb 2021. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/publications/cogme-rural-health-issue-brief.pdf

[iii] Government Accountability Office, Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding, GAO-18-240, Mar. 2018, at 29-30.
[iv] Council on Graduate Medical Education. Investing in a Health Workforce that Meets Rural Needs. Feb 2021. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/publications/cogme-rural-health-issue-brief.pdf

[v] Ibid. at 29-30