RURAL GRADUATE MEDICAL EDUCATION INNOVATION

RECOMMENDATION
The American Academy of Family Physicians (AAFP) urges U.S. Senators to sign on as original cosponsors of the draft Senate bill, *Rural Physician Workforce Production Act of 2018*, soon to be introduced by Sen. Cory Gardner (R-CO).

Background

The geographic maldistribution of primary care physicians is a problem in the United States. Rural areas disproportionately lack access to primary care physicians 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). 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,[i] 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 payment 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 training for those positions that are at least 50% rural (e.g. rural training tracks or "RTT").
    - The NPRP is equivalent to the national 85th 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 cost of rural and ambulatory training.

- 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 legacy 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.

3. **Payment to Critical Access Hospitals.** The bill equalizes GME payment for critical access hospitals (which make up 61% of all rural hospitals), using the same formula as urban hospitals. Currently, critical access hospitals are paid based on 101% of their reasonable costs, which does not include IME. Equalizing GME payment for critical-access hospitals will also incentivize urban hospitals to train more residents in rural locations as rotators.

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.

Why would rural and ambulatory training cost more than traditional training?
According to the GAO,[ii] "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."

For more information, contact the American Academy of Family Physicians' Government Relations Department at 202-232-9033.

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[i] 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.

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