

# Rural Graduate Medical Education

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National Rural Health Association

Approximately 20% of the U.S. population resides in rural areas, while less than 9% of U.S. physicians practice in rural areas. Family practice doctors are the most common rural physicians. All other specialties, including other generalist specialties, are more likely to settle in urban areas. The more specialized a physician is, the less likely practice in a rural area will occur.

The numerical increase in the number of physicians in the United States has not resulted in a proportional increase in physicians practicing in rural areas and has not relieved geographic maldistribution. In order to alleviate the rural physician shortage, medical education needs to change so that it selects, trains and deploys more health care workers who choose to practice in rural areas. This revised system would train health care providers who prefer rural practice, therefore streamlining recruitment and improving retention. Candidates interested in rural medicine can be profiled through three basic "truths" about rural health.

1. Students with a rural background are more likely to train in primary care and return to original areas.
2. Family Medicine is the key discipline of rural health care.
3. Residents trained in rural areas are more likely to practice in rural areas.

Many graduate medical education (GME) programs are attempting to redesign curricula to attract, expose and encourage students to become rural physicians. However, many rural residency programs face difficulties in obtaining funding and accreditation, due to Medicare regulations and shortfalls and requirements of the Residency Review Committee (RRC) for Family Practice of the Accreditation Council on Graduate Medical Education (ACGME) respectively.

## Funding Issues

A large portion of GME funding is provided through Medicare, as teaching facilities receive payments for direct and indirect costs of providing medical education and care to patients. Direct Medical Education (DME) payments help cover costs that are directly related to running a GME program, such as residents' salaries and benefits, supervising physicians' salaries, office space costs and overhead. This portion of the funding is generally paid to the hospital that pays all or most all of the resident's stipend and benefit costs. Indirect Medical Education (IME) payments address the added patient care costs associated with teaching hospital settings. The IME adjustment increases the DRG payment for each Medicare admission by approximately 5.5% for each 10% increase in the resident-to-bed ratio.

## NRHA Policy Brief

In 1998, only 70 out of 2,241 (3.1%) short-term, non-federal general hospitals located in non-metropolitan counties received Medicare GME payments. This contrasts with the 1,069 out of 2,823 (37.9%) hospitals in metropolitan counties receiving Medicare GME payments. Furthermore, the number of rural hospitals receiving GME payments has not grown significantly in recent years. If the number of rural hospitals participating in GME is to be increased, additional funding must be provided to rural programs.

### Rural Training Issues

Due to family practitioners' traditional role in rural health, that field has been the focus for increasing the number of rural doctors. Several components of family practice residency programs have been linked to graduating more rural physicians. These include:

- Required rural training (Programs which required more months of rural training had a higher percentage of graduates who began practice in rural communities);
- A rural focus or mission for the program;
- Four or more months of required obstetrical training;
- Training in less urban locations.

A variety of residency programs train physicians for rural practice:

- Rural-focused programs located in non-metropolitan areas and metropolitan programs with a rural mission contribute significantly to the training of rural family physicians.
- Rural Training Tracks

Another type of training program, the Rural Training Track (RTT), is specially designed for training rural physicians. RTTs are generally of two types. The first type of RTT is known as a 1-2 program. In these programs, at least part of the first year of training is done at a central, usually urban, site and at least the last two years are based at a rural site. There are more than 30 approved 1-2 programs in the U.S., but each program usually graduates only one or two physicians per year.

Another type of program that focuses on preparation for rural practice has recently been termed an Integrated RTT. This type of program uses a hub and spoke model where all residents in the program are based at a central location, but have required rural rotations and experiences that make up a significant portion of the curriculum. This can also be a rural focused non-metropolitan-based program that specifically works to prepare residents for rural practice. The Integrated RTT, however, has not been acknowledged or defined by the RRC.

## NRHA Policy Brief

The Balanced Budget Act of 1997 (P.L. 105-33) placed a cap on the number of medical residents that are eligible for Medicare direct and indirect GME payments. This limitation has negatively impacted the availability of funding to support rural residency programs. In the Balanced Budget Refinement Act of 1999 (Public Law 106-113), an exemption for the Integrated RTT was included that was intended to allow both 1-2 rural tracks and Integrated RTTs to be exempt from the GME funding freeze.

The Centers for Medicare and Medicaid Services (CMS) has stated that lack of a formal definition of an Integrated RTT has prevented the agency from exempting those programs from GME funding restrictions. In its rulemaking, CMS has noted that the BBRA does not define "rural tracks" or an "integrated rural track" and that there is "no existing definition" of these entities. CMS chose in its rulemaking to view the two terms as synonymous, essentially limiting the application of the exemption to 1-2 programs.

So that the exemption for the Integrated RTT may be implemented by CMS, a definition for the Integrated Rural Training Track has been developed by the NRHA Rural Medical Educators group. NRHA supports the following definitions of residency programs training physicians for rural practice:

A Rural Training Track can be one of the following:

- A 1-2 Rural Training Track

A family practice residency program with at least part of the first year of training based at a central location and at least the last two years of training based at a rural location

- An Integrated Rural Training Track

A family practice residency program with the following required components:

- a. at least 4 rural block months to include a rural public and community health experience. During a rural block rotation, the resident is in a rural area for 4 weeks or a month.
- b. a minimum of 3 months of obstetrical training or an equivalent longitudinal experience
- c. a minimum of 4 months of pediatric training to include neonatal, ambulatory, inpatient and emergency experiences through rotations or an equivalent longitudinal experience.
- d. a minimum of 2 months of emergency medicine rotations or an equivalent longitudinal experience so that the resident will be fully prepared to handle rural emergency situations.

## NRHA Policy Brief

NRHA further recommends that waiver of the cap on GME positions for "rural" programs be extended by including in the definition of "rural" any allopathic or osteopathic residency program which can document that over 50% of its graduates in the last three years are practicing in non-metropolitan areas.

For this document, rural is defined as located in a non-metropolitan area.

In summary, there is a widely acknowledged shortage of rural healthcare providers including physicians. Current methods for selecting and training medical students and residents do not appear to be alleviating the shortage. Funding for new programs in rural medical education has been greatly diminished and strategies for renewed funding and programs need to be developed. The NRHA is the leading group that advocates for the health of rural populations and promotes and advocates for the development of programs that will address the rural health provider shortage.

### Recommendations

The NRHA recommends that:

- The ACGME should allow flexibility in the development and curricula of rural training programs in adapting to local resources.
- The ACGME should acknowledge both 1-2 and Integrated RTTs as unique entities.
- Congress and CMS should simplify GME funding and link such funding to outpatient as well as inpatient care.
- CMS should, under the rural exemption granted in the BBA and BBRA, eliminate caps on GME funding for both new rural programs and existing programs desiring to increase the number of residents, provided that these programs have a significant track record of placing a high proportion of graduates in rural practice or are Rural Training Tracks or Integrated Rural Training Tracks as defined above.
- CMS and the RRC for Family Practice should adopt the definition of rural training tracks as proposed above. This would allow Integrated Rural Training Tracks and programs with a track record of graduating rural physicians to be exempt from the GME funding freeze intended by Congress in the Balanced Budget Refinement Act of 1999 (Public Law 106-113).

*Questions in regard to this policy brief should be directed to the NRHA Government Affairs Office at 703/519-7910*

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