SCHs, MDHs Can Improve Rural Physician Shortages

The Issue

Rural communities struggle to recruit and retain physicians, including most notably primary care physicians. Studies have shown that training physicians in rural areas increases the likelihood those physicians will practice in a rural community.[1] Yet, according to the Government Accountability Office, only two percent of residency training occurs in rural areas.[2]

The Department of Health and Human Services (HHS) and public health advocates have recommended that more physician training be localized in rural areas. The Council on Graduate Medical Education (COGME)[3] in an April 2022 report to the Secretary of HHS and Congress recommended the Centers for Medicare & Medicaid Services "eliminate regulatory and financial barriers that inhibit the development of rural residency programs" and "offer Medicare… exceptions for sponsoring institutions starting new rural-based training programs…in needed…geographic areas."[4]

Sole Community Hospitals (SCHs) and Medicare-dependent Hospitals (MDHs) are well-situated to host residency programs, but these hospitals are financially disincentivized to establish these programs. Under Medicare's Inpatient Prospective Payment System (IPPS), SCHs and MDHs are paid the greater of the federal rate (i.e., the payment that the hospital would otherwise receive under the IPPS) or a cost-based payment, which is determined by adding together the federal payment rate applicable to the hospital and the amount that the federal payment rate is exceeded by a hospital-specific rate (in the case of MDHs, the hospital receives 75% of that difference). Hospital-specific rates are pegged to a hospital's costs in a specified year (for SCHs the years are 1982, 1987, 1996 or 2006, and for MDHs the years are 1982, 1987 or 2002).

If an SCH or MDH did not have a teaching program prior to the year that is used to set its hospital-specific rate, the indirect costs of providing residency training are not reflected in that rate. If these hospitals establish a teaching program now, they will receive no extra money if the hospital-specific rate continues to exceed the federal rate. Even if a hospital had a teaching program in a base year, it faces similar disincentives to increase the number of residents trained in the program. Most rural hospitals lack the financial resources to establish a teaching program without some measure of additional financial support.

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[1] Hempel S, Maggard Gibbons M, Ulloa JG, Macqueen I, Miake-Lye I, Beroes J, et al. Rural Healthcare Workforce: A Systematic Review. VA Evidence-based Synthesis Program Reports. Washington, DC: Department of Veterans Affairs; 2015. 79.1.

[2] United States Government Accountability Office. Graduate Medical Education: Programs and Residents Increased during Transition to Single Accreditor; Distribution Largely Unchanged. GAO-21-329, (April 2021) p.24.

[3] COGME was authorized by Congress to provide advice and recommendations to the Secretary and Congress on physician workforce trends, training issues, and financing policies.

[4] Council on Graduate Medical Education, Twenty-Fourth Report to the Secretary of the U.S. Department of Health and Human Services and the U.S. Congress, "Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities," (April 2022) p. 12.

The Solution

If a hospital paid on the basis of the federal rate initiates a teaching program, it receives both Direct Medical Education (DME) and Indirect Medical Education (IME) payments. SCHs and MDHs, which comprise nearly 80% of hospitals eligible to establish training programs in rural communities, should receive the same incentives and financial buffer as hospitals paid under the federal rate. While they do qualify to receive DME payments, when paid their hospital-specific rate they do not receive IME payments.

SCHs and MDHs paid using their hospital-specific rate also should receive IME adjustments to encourage these hospitals to localize resident training in rural areas. The hospital-specific rate formula for SCHs and MDHs should not disqualify the hospital from receiving full IME payments as they would under the federal rate formula. This full federal funding of DME and IME payments is necessary to establish and operate rural based residency training programs.

Legislative Specifications

To accomplish this objective, amend section 1886(b)(3) by adding a paragraph that provides a to-be-determined future fiscal year for both SCHs and MDHs that develop or expand a resident training program after the year in which their hospital-specific rate was calculated—

1. For purposes of calculating applicable target amounts, estimates of indirect medical education costs for such hospital in the hospital's applicable base year, if any, shall be removed from the hospital's target amount; and
2. The hospital shall be eligible for an indirect medical education payment adjustment in the same manner as other subsection (d) hospitals as described in paragraph (5)(B).