National Rural Health Association Policy Brief

Rural track program funding: An erosion in definitions of rural places requires new action

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Introduction

A place-based approach to funding graduate medical education (GME) in rural communities is supported by compelling evidence of its effectiveness placing and retaining physicians in rural practice.[i,ii] Unfortunately, over the past five years this strategy has been undermined by an erosion in definitions of rural places. In this brief a rural track program (RTP) is defined as an accredited course of postgraduate training leading to certification in independent practice for any physician specialty, occurring in rural and urban places where less than 50 percent of training occurs in a geographically rural location by federal definition. It aligns with current definitions in ACGME accreditation,[iii] GME funding by CMS,[iv] and the U.S. Department of Health and Human Services 2021 strategic plan[v] and its associated report to Congress.[vi]

Training in rural communities has existed since the days before Flexner (1910), but over the past century, medical education and training has become increasingly urban.[vii] At the same time, the rural physician workforce has demonstrated significant decline in relation to urban and suburban communities. We now know 18 months of training in a rural location (as defined by rural-urban commuting area codes or RUCAs) more than doubles placement of graduates in rural community practice, and they are more likely to stay than residents trained in an urban location.[1,2] Although the physician workforce is only one of many determinants of health in any community, it is foundational to comprehensive health care access.

In December of 2020 the Consolidated Appropriations Act of 2021 (CAA2021) was signed into law and contained a new definition and several provisions for RTPs. Among other things, those RTP provisions: (1) did not require separate accreditation; (2) allowed for exemption of new RTPs from the rolling average calculation; (3) provided an opportunity for hospitals who had inadvertently set a low per resident payment factor (PRA) and low cap on training positions to reset that cap; and (4) exempted hospitals from establishing a PRA or cap with less than 1 FTE of physician training over the course of a year such as through occasional resident rotations). Final regulations were published in December 2021 and further refined in August 2022.[4,viii]

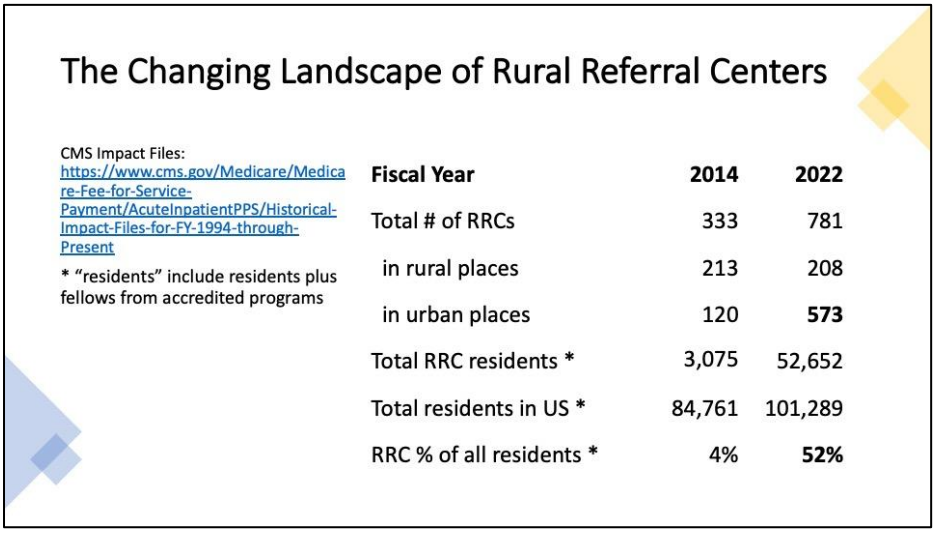
Unfortunately, this advance in funding for GME in rural places has collided with changes in rural hospital reclassification initiated by a series of lawsuits and court decisions starting in 2015 (Appendix A). Urban-rural wage indices and hospital reclassifications have a long history starting with the Hospital Inpatient Prospective Payment System (IPPS) in 1983. The Medicare Geographic Classification Review Board was established by the Omnibus Budget Reconciliation Act of 1989 to review and make determinations on geographic reclassification requests of hospitals who receive payment under the IPPS but wish to reclassify to a higher wage area for purposes of receiving a higher payment rate.[ix] Hospitals that bordered rural or urban communities and met the appropriate criteria could reclassify to improve their IPPS reimbursement. Rural hospitals have been reimbursed based on a rural wage index and floor that are generally less than the urban rate, which has prompted some rural hospitals to reclassify as urban.

Since FY2018, a growing number of U.S. hospitals[1] have taken advantage of a court decision and a subsequent CMS final rule that allows them to reclassify from an urban to a rural geographic designation. The facilities then reclassify their wage index back to urban while retaining the geographic rural designation for other purposes one year later.[x]

Although a major driver of reclassification is typically the positive impact on clinical payments (such as 340B drug program at a lower disproportional share threshold), there are also significant implications for a teaching hospital's GME reimbursement.[xi] Section 1886(d)(8)(E) of the Social Security Act is interpreted to mean that when a hospital is "reclassified as rural" it must be treated as if it is geographically rural for all IPPS purposes, including IME. Urban hospitals reclassified as rural receive an immediate 30 percent increase in their cap for indirect medical education (IME) reimbursement. The increased IME cap immediately results in increased Medicare IME payments if the hospital has been claiming more resident FTEs than its cap allowed. Many hospitals have a history of claiming more resident and fellow FTEs than their cap and as a result not getting Medicare GME payments for all their trainees. Taken as a whole, U.S. hospitals were claiming 16 percent FTE residents above their IME cap and 23 percent above their DGME cap in FY18 (analysis of Graham Center data from FY18[xii]).

Analysis

The cap increase from the rural reclassification of urban hospitals will translate to an immediate payment increase for many large teaching hospitals and create opportunity for expansion. In addition to the immediate 30 percent IME cap increase, a rural reclassification can increase a hospital's IME cap further if the facility starts an accredited residency or fellowship program in any specialty. CMS data demonstrate this change in terms of the number of residents in the United States being claimed by and training in these hospitals:



The Changing Landscape of Rural Referral Centers

CMS Impact Files: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Historical-Impact-Files-for-FY-1994-through-Present

* "residents" include residents plus fellows from accredited programs

Fiscal Year	2014	2022
Total # of RRCs	333	781
in rural places	213	208
in urban places	120	**573**
Total RRC residents *	3,075	52,652
Total residents in US *	84,761	101,289
RRC % of all residents *	4%	**52%**

Reclassified rural hospitals that acquire these new GME cap positions will not, under the current rules, be required to expand their GME programs with any attention to alleviating physician workforce deficiencies in communities that are rural by geospatial location.

[1] Section 401 and 412.103 hospitals, in reference to the Federal Code

In a surprising twist, these rules also allow two rural reclassification hospitals (both in urban places) to partner in starting a new rural track program. using the "urban" geographic location of one hospital and the "rural" classification of the other. Thus, an urban-located hospital with rural reclassification can start and get payment from CMS for a rural track program in which resident trainees receive no actual training outside a metropolitan statistical area.

This explosion in rural reclassifications is creating significant opportunity for GME expansion but with none of it obligated towards training in actual rural communities. This could have a potentially crippling effect on new and existing rural residencies and the communities they serve. It is no longer necessary for an urban hospital to partner with a rural hospital at a distance to start new programs, in effect nullifying the urban hospital's IME cap on new program residency positions that was established in 1997. In fact, there are disincentives to partnering, including decreased GME funding, the need for affiliation agreements with hospitals generally at a distance and sometimes outside their own health system, rules of accreditation that place limits on the location of resident rotations, and distributed governance.

These rules also create disincentives to forming RTPs truly anchored in rural communities. An urban hospital reclassified as rural is at a funding disadvantage relative to a non-reclassified urban hospital that can receive fully paid direct GME and IME even if the RTP is not a separately accredited program. Like other rural community hospitals, a reclassified rural hospital still requires separate accreditation to receive the IME portion of GME funding. Rural community hospitals may now have even more difficulty collaborating in the development of an RTP with urban hospitals that now have less financial reason to partner. Existing RTP programs may lose their urban affiliates.

As rural definitions erode, the surge in rural residency positions witnessed over the past decade that resulted from investments by HRSA and its Federal Office of Rural Health Policy and Bureau of Health Workforce will likely abate and is at high risk of receding. These rules have essentially removed almost all CMS funding preferences for residents to be trained in geographically rural places and undermines currently proposed legislation to support rural training (S1893[xiii] and others). Rural communities already at a disadvantage in hosting GME training will have increasing difficulty with health care access and physician shortages.

NRHA has always supported policies supporting rural GME and currently supports policies and legislative proposals relevant to the rural physician workforce[xiv] including the following papers:

Toward a Sustainable and Diversified Rural Health Workforce, February 2022
Includes as a policy lever funding for rural training tracks, now called RTPs

Rural Carve-out Funding, September 2021
Encourages agencies to define rural using guidelines from HRSA's Federal Office of Rural Health Policy

Rural Obstetric Unit Closures and Maternal and Infant Health, February 2021
Recommends expanding rural-focused family physician and general surgeon programs with OB fellowship training

Access to Rural Maternity Care, January 2019
Supports providing more rural residencies for family practice physicians, the dominant provider of maternity services in rural communities, that allow residents to perform more deliveries**, a policy jointly adopted by the American Academy of Family Physicians, April 2014** (updated from a prior statement in 2008)

Policy recommendations

The goal of the following targeted recommendations is to:

(1) assure current and future funding of RTPs and other streams for GME in geographically rural locations flow to programs meeting the original intent that greater than 50 percent of training occur in actual rural **locations**, and not in urban-located facilities **reclassified** as rural;

(2) create a mechanism to pilot other models for rural GME funding;

(3) initiate a process to track outcomes of rural GME funding policies.

Recommended actions

- Exclude urban hospitals reclassified under Section 1886(d)(8) € of the Social Security Act from qualifying for the "less than 50 percent rural training" requirement of a new RTP programs under Section 127 of the CAA2021. Such urban hospitals should, however, be able to fully participate in such programs as the urban partner if the program is separately accredited.
- Pursue new legislation (RTP repair) that will restore the prospect of sustaining existing RTPs and the potential for developing new GME positions in geographically rural locations:
    - Better target GME funding using sub-county rural definitions for the purpose of workforce development in areas of need, using sub-county RUCA codes or Census block definitions rather than core-based statistical areas. For this purpose and to provide sustainable funding allow the use of either of the most recent two decennial censuses.
    - Change the requirement for less than 50 percent to more than 18 months for all specialties. This creates more achievable rural program options for specialties requiring more than three years of training, particularly general surgery and obstetrics/gynecology.
- Require outcome data for all GME funding that identifies rural community practice as an intended outcome.
- Create mechanisms to pilot new models for rural GME funding as recommended by the IOM Report of 2014[xv]:
    - Develop an alternative place-based payment mechanism to traditional Medicare GME for funding rural GME
    - Establish a single per-resident payment for rural GME positions that like teaching health center GME is not mired in the complexities of hospital finance.
    - Add funding for interprofessional health professions training in rural locations.

Conclusion

A place-based approach to funding graduate medical education (GME) in rural communities is supported by compelling evidence of its effectiveness placing and retaining physicians in rural practice.[xvi,xvii] Unfortunately, over the past five years this strategy has been undermined by an erosion in definitions of rural places. This brief recommends actions intended to restore the prospect of sustaining existing RTPs and the potential for developing new GME positions in geographically rural locations. A healthy physician workforce is one key to health care access in rural communities across our nation.

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Appendix:

A history of court decisions and regulation regarding rural reclassifications

August 1, 2022

Summarizes this history in CMS comments

https://www.cms.gov/newsroom/fact-sheets/fy-2023-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective

42 CFR § 412.103 - Special treatment: Hospitals located in urban areas and that apply for reclassification as rural; legal Information Institute summary with links to relevant final rules

https://www.law.cornell.edu/cfr/text/42/412.103

2015

Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services, 794 F.3d 383 (3d Cir. 2015)

https://caselaw.findlaw.com/us-3rd-circuit/1708592.html

Lawrence + Memorial Hospital v. Burwell, No. 15– 164, 2016 WL 423702 (2d Cir. Feb. 4, 2015)

https://cases.justia.com/federal/appellate-courts/ca2/15-164/15-164-2016-02-04.pdf?ts=1454605209

2016

Implications from Geisinger are in the April 21, 2016, interim final rule with comment period (IFC) (81 FR 23428 through 23438): https://www.govinfo.gov/content/pkg/FR-2016-04-21/pdf/2016-09219.pdf

Main takeaway: CMS allows simultaneous 412.103 and MGCRB reclassifications, and 412.103 hospitals can use rural criteria to then qualify more easily for MGCRB reclassifications afforded to rural hospitals. An urban hospital under 412.103 remains "urban" for purposes of DGME but is "rural" for purposes of IME. For a new RTP program (separately accredited and meeting new program criteria), the urban-located rural reclassified hospital can get new DGME under the rural track rules as long as it had not previously set its RTT cap for that specialty and can get new IME as a rural hospital for a truly new program (not under the rural track rules).

2019

Final rule recalculation of rural WI floor

https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf

2020

Bates Cnty. Mem'l Hosp. v. Azar, Civil Action No. 19-17672021

https://cases.justia.com/federal/district-courts/district-of-columbia/dcdce/1:2019cv01767/208388/28/0.pdf?ts=1589548595

More to the point of how CMS must consider 412.103 hospitals as rural for all purposes:

FY 2022 IPPS/LTCH PPS final rule (86 FR 45187) https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf : CMS finalized an IFC to implement Bates court case that required them to allow 412.103 hospitals to meet MGCRB reclassification criteria using their reclassified rural area's wage data for their geographic location.

July 14, 2022

20-707 - CITRUS HMA, LLC et al v. AZAR, Case 513-7A

August 10, 2022

FY 2023 IPPS/LTCH PPS final rule (87 FR 49002 – 49004) https://www.govinfo.gov/content/pkg/FR-2022-08-10/pdf/2022-16472.pdf :

As a result of the Citrus court case, CMS will need to include the wage data of urban hospitals reclassifying as rural under 412.103 in the calculation of the rural floor (something CMS used to do but stopped in FY 2020 to combat gaming in states where the rural floor was set strategically by high-wage hospitals reclassifying to rural).

2022

Current litigation includes Deaconess Hospital, regarding how CMS treats 412.103+MGCRB as just MGCRB in rate setting.

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[xiii] Senate Bill 1893, Rural Physician Workforce Production Act of 2021. Summary and text available at: https://www.congress.gov/bill/117th-congress/senate-bill/1893

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