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Congressional Briefing: Increasing access to medicare-funded physician residency slots

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Commonwealth Policy Institute 2023 Congressional Summit

Center for Health Disparities

Increasing Access to Medicare-funded Physician Residency Slots

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Summit Background

This policy brief - which recommends new development of a federal policy measure - is derived from the 2023 Congressional Summit meetings of the Commonwealth Policy Institute think tank. The Commonwealth Policy Institute (CPI) is nonpartisan, evidence-based policy think tank, founded with its first chapter at the University of Louisville, and is acknowledged as resource for tailored policymaking in Kentucky under bicameral resolutions of the KY General Assembly. Under its stream of work conducted as public service, CPI forms policy centers combining university level research of faculty and university community members with input of stakeholder groups, businesses, and policymakers to create tailored policy solutions to needs faced across the Commonwealth of Kentucky. As many issues we address are common to other states, and as discussion across the states at a federal level may incubate new ideas which may be tailorable to Kentucky, each year CPI conducts an annual Congressional Summit for the purpose of leveraging the federal system for policy diffusion -- rapidly "trickling up" ideas from our state-level policy design into a federal context, or, "trickling down" new policy approaches that may be re-designed for implementation in the Commonwealth.

Introduction

The Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) final rule designated the Centers for Medicare & Medicaid to implement 1,000 new Medicare-funded physician residency slots to qualifying hospitals authorized by the Consolidated Appropriations Act (CAA) of 2021, phasing in 200 slots per year over five years.[1] However, in its first round of allocation of 200 slots in 2023, only 5 rural hospitals in the country received slots, despite Section 126 of the CAA mandating that at least 10% of the total slots go to hospitals in rural areas and that no single hospital can receive more than 25 additional full-time equivalent residency slots.[2, 3]

[1] *FY 2022 IPPS final rule home page*. CMS.gov. (2023, February 26). https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page

[2] *Direct graduate medical education (DGME)*. CMS.gov. (2023, April 11). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME

[3] House Resolution 133, Consolidated Appropriations Act of 2021. Retrieved from https://www.congress.gov/bill/116th-congress/house-bill/133/text.

In order to receive additional full-time equivalent residency slots, a hospital must qualify in at least one of the following four categories: (1) hospitals in rural areas (or treated as being located in a rural area under the law); (2) hospitals training a number of residents in excess of their Graduate Medical Education cap; (3) hospitals in states with new medical schools or branch campuses; and (4) hospitals that serve areas designated as health professional shortage areas (HPSAs). This fourth eligibility category refers only to *geographic* HPSAs and not *population* HPSAs.[4]

The shortfall of slots allocated to rural hospitals could be due to a number of factors. For one, there may be an outreach issue on the part of CMS to make rural hospitals aware that they can apply for Section 126 slots. According to data from the National Rural Health Association, only 9 rural hospitals applied for slots, suggesting that perhaps they did not know they had the opportunity to apply.[5] In addition, many rural hospitals may not have the resources or capacity to take on residents.

Most importantly, though, many urban hospitals take advantage of the loose interpretation of Section 1886(d)(8)(E) of the Social Security Act and have begun to classify as rural hospitals.[6] This is often for those hospitals that border rural or urban communities and meet the appropriate criteria.[7]

These hospitals reclassify to improve the reimbursement they receive from the Inpatient Prospective Payment System (IPPS). These newly reclassified hospitals are then treated as if they are geographically rural for all IPPS purposes, including Indirect Medical Education (IME). IME costs are the additional patient care costs associated with the training of interns and residents.[8] Urban hospitals that reclassify as rural receive an immediate 30% increase in their cap for IME reimbursement. The increased IME cap immediately results in increased Medicare IME payments if the hospital has been claiming more resident full-time equivalents than its cap allowed. Thus, an urban-located hospital with rural reclassification can receive payment from CMS for their rural track

[4] *What is shortage designation?*. What Is Shortage Designation? | Bureau of Health Workforce. (2023, April). https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas

[5] Morgan, A. (2023, February 13). National Rural Health Association. Retrieved from https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2023/NRHA-letter-GME-slot-distribution.pdf.

[6] Social Security Act, 42 U.S.C. § 1395ww(d)(8)(E).

[7] Longenecker, R., & Rodefeld, L. (2022). (issue brief). *Rural track program funding: An erosion in definitions of rural places requires new action*. Washington, D.C.: National Rural Health Association. Retrieved from https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Policy-Paper-final-Rural-Reclassified-Hospitals-and-RTPs.pdf.

[8] Nguyen, N. X., & Sheingold, S. H. (2011). Indirect medical education and disproportionate share adjustments to Medicare inpatient payment rates. *Medicare & medicaid research review*, *1*(4).

residency program, despite their resident trainees receiving no training outside a metropolitan statistical area.

In sum, these barriers make it more difficult for geographically rural hospitals to receive Section 126 physician residency slots. Given that one of the greatest indicators of where a physician will practice is the location of their residency, these roadblocks need to be removed for the federal government to properly address the rural healthcare workforce shortage.[9]

Recommendations

- Congress should encourage CMS to exclude geographically urban hospitals reclassified under Section 1886(d)(8)e of the Social Security Act from qualifying for the "greater than 50 percent rural training" requirement of a new Rural Track programs under Section 127 of the CAA 2021. Such urban hospitals should, however, be able to fully participate in such programs as an urban partner of a rural hospital if the program is separately accredited.
- Over the remaining 4 years of distribution, Congress should encourage CMS to prioritize outreach to rural hospitals on this opportunity to apply for residency slots.
- The fourth eligibility category under Section 126, should be expanded by CMS to refer to both *geographic* HPSAs and *population* HPSAs.

[9] Fagan EB, Finnegan SC, Bazemore AW, Gibbons CB, Petterson SM. Migration after family medicine residency: 56% of graduates practice within 100 miles of training. American Family Physicians. 2013 Nov 15;88(10):704. PMID: 24364487.