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Academic Health Focus

Addressing Rural Physician Shortages: The Critical Role for AMCs as Partner

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The U.S. expects a national physician shortage of between 54,100 and 139,000 physicians by 2033.[1] The burden will hit rural communities the hardest. A recent survey of final-year residents showed that only one percent of those surveyed prefer to practice in a community of 10,000 people or fewer and only two percent want to work in a community with 25,000 or fewer.[2] With nearly 20 percent of the U.S. population living in rural areas and only 11.4 percent of physicians practicing in them,[3] solutions are needed.

While the shortage is driven by a combination of factors, a key piece of the puzzle is where physicians train. National and state workforce data consistently show that physicians are most likely to practice in the region where they complete their training. Between 2005 and 2015, 99 percent of board-eligible physicians trained in urban settings.[4]

Expanding medical education in rural areas is one approach to improving access to healthcare in rural areas. It is an endeavor that's not without challenges. A recent study conducted by the Collaborative for Rural Primary Care Research, Education, and Practice (Rural PREP) found that the greatest predictors[5] of a medical school's contribution to graduating physicians who will practice in rural areas were:

- Osteopathic
- Rural location
- Public
- Rural scholarly output

New medical schools were noted in the study as having a positive impact on producing rural providers, which may be a function of many of them being either osteopathic or public community-based schools established as a result of public

Key Board Takeaways

- Establish/expand affiliations with hospitals and health systems that serve rural communities to address local needs, reinforce referral relationships, create opportunities for clinical collaborations, and enhance the AMC's regional reputation.
- Measure and document the AMC's impact on addressing rural healthcare needs. Promote this information to commercial and governmental payers, state agencies, and elected officials to secure incremental support for the AMC.
- Advocate at federal and state levels for financial support to expand existing educational programs as a cost-effective and practical way to address the current and future needs of underserved rural communities.

1 Association of American Medical Colleges, "New AAMC Report Confirms Growing Physician Shortage," June 26, 2020.

2 Merritt Hawkins, *2019 Survey: Final-Year Medical Residents: A Survey Examining the Career Preferences, Plans and Expectations of Physicians Completing Their Residency Training*.

3 Daniel G. Mareck, M.D., "Federal and State Initiatives to Recruit Physicians to Rural Areas," *AMA Journal of Ethics*, May 2011.

4 United States Government Accountability Office, *Physician Workforce: Locations and Types of Graduate Training Were Largely Unchanged, and Federal Efforts May Not Be Sufficient to Meet Needs*, May 2017.

5 Davis Patterson, Ph.D., "Which Medical Schools Are High Producers of Rural Primary Care Physicians and What Factors Explain Their Success?" Lecture, Research Design and Dissemination Studio, NOSORH Annual Meeting, Cheyenne, WY, October 18, 2018.

policies designed to address physician workforce shortages.

Rural Physician Training Toolbox

Establishing and operating medical education programs in rural areas is complex. Rural hospitals are limited in their ability to support a well-rounded clinical training experience with an adequate and diverse number of educational experiences and qualified clinical educators to teach. Financial considerations can also limit a hospital or health system's ability to participate in the academic mission. Despite the challenges, expanding medical education to rural locations can and has been pursued. The following initiatives have produced meaningful results:

Expanded Funding to CAHs

CMS has made efforts to bolster rural training for physicians. Based on a final rule that went into effect in October 2019, urban teaching hospitals can claim residency rotations at critical access hospitals (CAHs).[6] In the past, GME leaders may have been less likely to rotate residents into CAHs knowing that there was no potential reimbursement. This new opportunity provided by the 2019 inpatient prospective payment system rule could help offset the cost of placing trainees in these facilities. If urban-based residents are afforded rural hospital rotations during their training, they may find the experiences fulfilling and later choose to practice in such a location.

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Incremental Reimbursement for New Programs in Rural Settings

Unlike urban hospitals, rural and rurally designated hospitals are eligible to garner additional Medicare GME reimbursement for new residency programs established after the initial cap-setting period. Hospitals that reclassify from urban to rural become eligible for this rural hospital exception to the resident FTE cap-setting rules for indirect medical education (IME) reimbursement only. Urban hospitals with a historical resident FTE cap that undergo a rural reclassification are eligible to claim up to 130 percent of their existing IME resident FTE cap as well as incremental IME reimbursement for new training programs established after the transition; these programs would be ineligible for new reimbursement absent the reclassification.

RTT Program Design

One strategy available to family medicine residencies is rural training tracks (RTTs), in which residents work for at least half of their training program in a rural location.[7] In FY 2019, the Health Resources and Services Administration (HRSA) received a $10 million grant to support the Rural Residency Planning and Development Program, which provides funds to rural hospitals and federally qualified health centers (FQHCs) to develop RTTs.

The funding builds on the FY 2018 Medicare appropriation of $15 million to support RTTs. Concurrently, the HRSA grant money provides start-up funding for new RTT programs, which may be eligible for traditional Medicare GME reimbursement. Urban hospitals and systems acquiring regional rural hospitals should consider the prospect of using the RTT option to expand GME participation.

HRSA Grants

HRSA recently announced additional funding in the amount of $107.2 million to help increase the workforce in rural and underserved areas.[8] The awards were widespread, with over 300 organizations from 45 states receiving funding. Among the programs benefitting from the allocation are primary care residencies whose goal is retaining providers in disadvantaged regions.

National Health Service Corps

The National Health Service Corps (NHSC) is a federal program that offers scholarship and loan repayment programs for physicians and other primary care providers working in underserved locations.[9] Currently, about half of the 7,500 NHSC professionals practice in

6 Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals*, Federal Register, Vol. 84, No. 159, August 16, 2019.

7 Association of American Medical Colleges, *Rural Training Track Programs: A Guide to the Medicare Requirements*, 2017.

8 Kelly Gooch, "HHS gives $107.2M to fund health training in rural and underserved areas," *Becker's Hospital Review*, June 19, 2020.

9 Mareck, 2011.

HRSA-supported health centers, which deliver preventive and primary care services.

State Initiatives

States particularly in the West and the South are investing public funds in new approaches to expand physician training and address the rural physician shortage. Some examples include the following:

- In 2016 the New York Institute of Technology (NYIT) College of Osteopathic Medicine opened a regional campus at Arkansas State University in Jonesboro.[10] Medical students earn their degrees from NYIT but train in Jonesboro.
- Texas has more formally strived to retain medical students who are graduating from new publicly funded medical schools by pursuing and funding a goal of 1.1 to 1.0 residency positions per medical school student.[11]
- Georgia academic institutions are focused on starting new training programs as well as recruiting physicians to rural settings in the state. Grant start-up funds are made available from the state to qualified facilities. Additionally, the Medical College of Georgia plans to offer three years of medical school and a fourth year for a primary care residency in pediatrics, family medicine, or internal medicine. Students would then leave for a rural locale of care or an underserved county to practice for six years and be eligible for tuition reimbursement.[12]
- The Georgia Board of Health Care Workforce operates programs designed to motivate physicians to practice in rural communities by helping pay medical education debt. The physician loan repayment program is now available to about 30 rural physicians each year, and selected physicians can receive up to $25,000 per year and up to $100,000 for four years.[13] And in 2016, the governor signed legislation to create a $420 million tax credit program over seven years, beginning in 2018, to encourage individuals and corporations to contribute to Georgia's rural hospitals and other CAHs.[14]

10 Ellen Wexler, "Need Rural Doctors? Import a Medical School," *Inside Higher Ed*, May 13, 2016.
11 Jordan Sloan, "Number of Texas medical students causes residency growing pains," *The Battalion*, January 25, 2016.
12 Allyson Burger, "MCG hopes to offer incentive program to send doctors to rural areas," *WRDW*, February 29, 2019.
13 See https://healthcareworkforce.georgia.gov/loan-repayment-scholarship-programs/loan-repayment-programs.
14 See https://www.georgiaheart.org/about.

A Collaborative Approach Works Best

Nearly all the approaches described above require some degree of partnership. Resolving the physician shortage predicament is a significant challenge, especially in rural areas. Developing and expanding high-quality rural training opportunities is one crucial step to tackling this complex issue and ultimately improving access to care and the health of rural populations.

Perhaps the greatest opportunity to address the rural physician shortage is for healthcare organizations and academic institutions to work together and develop regional approaches to training. When entities such as hospitals, FQHCs, rural health clinics, area health education centers, CAHs, schools of medicine, and health science universities create new and durable affiliations, they are able to pool resources, and in some cases access new resources, to try novel approaches to rural training.

This challenge cannot be met by rural hospitals alone; partnerships with urban AMCs are required to expand training in communities where the provider need is most acute. These affiliations often complement clinical affiliations among these same entities and serve to deepen their investment in one another's success.

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