



# National Advisory Committee On Rural Health and Human Services



## The Rural Implications of Key Primary Care Provisions In the Affordable Care Act

White Paper September 2011

*Editorial Note: In 2011, the National Advisory Committee on Rural Health and Human Services will focus on the rural implications of key provisions from the Patient Protection and Affordable Care Act through a series of white papers with policy recommendations for the Secretary of the U.S. Department of Health and Human Services.*

### INTRODUCTION

The Affordable Care Act (ACA) includes several provisions that seek to address long-standing challenges in the training and placement of primary care providers in communities of need. The emphasis on primary care recognizes that any expansion in insurance coverage nationally is linked to an ongoing need to expand the ranks of primary care providers to care for this population. This paper addresses four specific ACA provisions and provides recommendations for program and policy changes that would help HHS address concerns in rural communities. The specific provisions are:

- Expansion of the National Health Service Corps (Section 5207)
- Re-Allocation of Unused Medicare Graduate Medical Education Physician Residency Positions (Section 5503)
- The Teaching Health Center Program (Section 5508)
- The Nursing Graduate Medical Education Demonstration Program (Section 5509)

### Recommendations

1. The Committee recommends that the Secretary examine the feasibility of allowing NHSC participants to be placed in a geographic area of their choosing consistent with allocating resources to the areas of greatest need.
2. The Committee recommends that the Secretary allow part-time nursing students enrolled in advanced-practice training programs to be eligible for the NHSC Scholarship program.
3. The Committee recommends that the Secretary track the re-allocation of Graduate Medical Education Physician Residency positions to determine how many of the residents chose to practice in primary care and the proportion that elected to practice in a rural community.
4. The Committee recommends that the Secretary require any programs funded under the Nursing Graduate Medical Education Demonstration Program include significant training and allocation of training dollars for community-based ambulatory training sites and that preferences be given to applicants that include rural community-based training sites.
5. The committee recommends that the Secretary, under Section 301 of the Public Service Act, conduct a demonstration project to identify the most effective ways to expand the number of accredited community based primary care residency program

These provisions, along with a number of other payment provisions within the legislation, provide the opportunity to improve access to primary care in rural communities. Rural areas have long struggled to attract needed physicians and other health care providers. Rural counties had on average 62.0 primary care physicians for every 100,000 residents in 2008, compared with 79.5

primary care physicians for the same number of residents in urban areas.<sup>1</sup> In addition, 65 percent of primary care health professional shortage areas (HPSA) are in rural counties.<sup>2</sup>

The lack of primary care access in rural communities has downstream effects. For instance, rural populations not only exhibit a greater propensity to report a health status of “fair” or “poor,” but they are less likely to visit a health care provider to receive appropriate preventative services<sup>3</sup>. This is particularly troubling when we consider, for example, that rural residents, in comparison to their urban counterparts, are more likely to be obese (27.4% versus 23.9%), suffer from diabetes (9.6% vs. 8.4%)<sup>4</sup>, and exhibit higher rates of heart disease (12.2% versus 10.3%)<sup>5</sup>. The disproportionate prevalence of chronic disease among rural populations underscores efforts to strengthen access to primary care.

## DISCUSSION & RECOMMENDATIONS

### *The National Health Service Corps—ACA Section 5207*

Since its inception in 1972, the National Health Service Corps (NHSC) has played a critical role in ensuring the recruitment and long-term retention of rural primary care practitioners. More than half of the current field strength is located in rural communities.<sup>6</sup> The NHSC has long been a lifeline in rural communities and the expansion of this program under the American Recovery and Reinvestment Act, as well as the ACA, has dramatically expanded the ability of this program to address at least part of the workforce challenge facing rural communities.

The Committee visited Kalkaska, Michigan in June and heard from a panel of current and former NHSC participants about their experiences with the program. Panelists in that discussion suggested several measures that could be implemented to improve the NHSC program. In particular, the panelists articulated that the “matching process” (between NHSC participants and service sites) could be improved by shortening the length of time it takes to reach a final placement decision, which could be accomplished with a more streamlined application<sup>7</sup>.

In the past few years, HRSA and the Bureau of Clinician Recruitment Services, which administers the NHSC, have taken significant steps to bring efficiencies to the application process, as well as improving matches between clinical service sites and the NHSC clinicians. The Committee, however, understands that inherent in the NHSC authority is the need to place clinicians in high-need areas, while also taking into account the interests of the clinician. Within that process, though, the Committee recommends that the Secretary examine the feasibility of a system in which NHSC participants are guaranteed, at minimum, a placement in a geographic area of their choosing consistent with allocating resources to the areas of greatest need. Specifically, the NHSC would be responsible for specifying the boundaries of the geographic area, while preserving the practice of assigning participants to site locations with the highest HPSA scores.

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<sup>1</sup> *Analysis of Area Resource File and the 2008 American Medical Association Physician Masterfile*, National Center for Health Workforce Analysis, Health Resources and Services Administration

<sup>2</sup> *Designated Health Profession Shortage Area (HPSA) Statistics*, Office of Shortage Designation, Bureau of Health Professions, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. Accessed August 11, 2011 <<http://datawarehouse.hrsa.gov/hpsadetail.aspx>>

<sup>3</sup> Larson, S. and Fleishman, J. “Rural-urban differences in usual source of care and ambulatory service use: analyses of national data using Urban Influence Codes,” *Medical Care*. 2003 Jul;41(7 Suppl):III-65—III-74.

<sup>4</sup> Bennett, K., Olatosi, B. and Probst, J. *Health Disparities: A Rural-Urban Chartbook*. South Carolina Rural Research Center. June 2008.

<sup>5</sup> Adams, P., Martinez, M. and Vickerie, J. “Summary health statistics for the U.S. population: National Health Interview Survey, 2009”. National Center for Health Statistics. *Vital Health Statistics* 10(248). 2010.

<sup>6</sup> The Geospatial Data Warehouse, Health Resources and Services Administration, July, 2011.

<sup>7</sup> These sentiments were expressed by participants of a panel on primary care at the June 2011 Meeting of the National Advisory Committee on Rural Health and Human Services, held in Traverse City, Michigan

Nursing students enrolled in part-time graduate nursing programs are currently excluded from participation in the NHSC scholarship program. The Committee believes that these students play an integral role in the effort to increase the number of clinicians practicing in rural communities. The Committee recommends that the Secretary revise the NHSC program regulations to allow scholarship recipients to attend a graduate school nursing training program part-time, to prevent the exclusion of non-traditional students from participation in the NHSC.

The Committee commends the Administration for the recent announcement from the White House Rural Council that the NHSC would expand site eligibility to Critical Access Hospitals (CAH). The Committee had previously recommended this change in its 2010 report. The Committee believes that this change will help rural communities address long-standing primary care workforce challenges by creating more potential service sites for NHSC placements. The Committee also believes that other small rural hospitals could benefit from NHSC placements. The Secretary should assess the effects of expanding loan repayment beyond CAHs to these hospitals.

#### *Graduate Medical Education (GME) Residency Redistribution—ACA Section 5503*

Medicare provides support for the training of physician residents through graduate medical education payments that cover both the direct and indirect costs of this training. The current number of residents covered is capped at levels established in 1997, and because of this, the Committee believes the current system is heavily weighted toward urban-based hospital programs that provide specialty training.

Under the guidance of Section 5503 of the ACA, the Centers for Medicare and Medicaid Services (CMS) recently redistributed unused GME residency slots to eligible hospitals that operated residency programs. The ACA specified that 65 percent of unused residency slots could be redistributed to hospitals that satisfied criteria outlined in Section 5503. From this pool, the statute mandated that 70 percent of the unused residency slots be redistributed to hospitals in states with resident-to-population ratios in the lowest quartile, and the remaining 30 percent be redistributed to hospitals in rural areas or in states with the highest proportion of their populations living in a health professional shortage area.

This provision was championed by primary care advocates who saw it as a way to re-orient current Medicare GME payments to focus on primary care training and to promote more training of those residents in rural and underserved areas. This is the second piece of legislation in recent years to re-allocate unused residency slots.

Of the fifty eight hospitals that received the unused GME residency slots, five were located in a rural area. While the Committee believes the redistribution of GME residency slots is an important step in the right direction, as this redistribution helps increase the number of primary care practitioners and ensures a more efficacious allocation of limited resources, the Committee would like to see a greater focus on rural hospitals when considering future GME residency slot redistribution initiatives.

Consequently, the Committee recommends that the Secretary develop a monitoring program to evaluate the effectiveness of the recent redistribution in meeting emerging primary care needs of rural residents. Specifically, HHS should track how many of the new residency slots are used to train residents that end up in rural practice, which would help identify those residency programs with a proven track record in producing rural primary care physicians.

Using the findings from the monitoring program, the Committee urges that the Secretary work with Congress and the Administration in the future to stipulate that redistributed GME residency positions are allocated to existing residency programs with a demonstrated ability to train primary care physicians that continue to practice in a rural setting after the duration of their residency program.

*Nursing Graduate Medical Education Demonstration Program—ACA Section 5509*

Section 5509 of the ACA establishes up to five hospital-based graduate nurse education demonstration projects for the clinical training of advanced practice registered nurses (APRNs). The statute mandates that all training programs must occur in, and be administered by, a hospital organization. Yet, there is a concern among APRN educators that relying only on hospital-based training may promote more specialized medical training that contradicts efforts to increase the number of primary care providers who are trained and educated to meet the needs of rural patients. Advanced practice nurses will play a key role in meeting the emerging primary care needs of this country, particularly in rural communities. This demonstration project provides an opportunity to design a training methodology that emphasizes community-oriented primary care training experiences, but only if the funding flows to the community-based sites. The Committee recommends that the Secretary require any programs funded under the Nursing Graduate Medical Education Demonstration Program include significant training and allocation of training dollars for community-based ambulatory training sites and that preferences be given to applicants that include rural community-based training sites.

*Teaching Health Centers—ACA Section 5508*

The ACA authorizes the establishment of teaching health center (THC) development grants to establish or expand primary care residency training programs in health centers, which are community-based ambulatory patient care centers such as Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). The ACA provided \$230 million over five years to support the THC program.

There has been growing support for examining new training models for physicians that emphasize community-based settings rather than the current residency model, which is heavily predicated on training in large urban-based hospital settings. Advocates believe that the THC model can help promote and train physicians in settings that emphasize the concepts of community-oriented primary care.

The promise of this program, unfortunately, was hampered by restrictions in the statute. Eligible entities include community-based ambulatory patient care settings that operate a primary care residency program. The eligible entity must be listed as an institutional sponsor by the relevant accrediting body. Corporate entities that are consortia of an eligible entity and hospitals operating one or more primary care graduate medical education program may be listed as the institutional sponsor, but must ensure that the community-based ambulatory training site is a central partner in the consortium.

The practical impact of this restriction meant any potential applicant had to be accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA) and recognized as the “sponsoring institution” by the accrediting body. While there were some FQHCs, RHCs, and CAHs taking part in accredited teaching programs, few were designated as the “sponsoring institution” of the residency program in their accreditation application.

Over this past year, HRSA funded 11 THC's in the first round, but only 2 THC's were located in a rural area. A significant proportion of rural health care entities such as FQHCs, RHCs, and CAHs were not eligible to apply.

The ACA authorization provided authority for both planning/technical assistance activities as well as implementation activities, but the appropriation language limited the funding solely to implementation. The ability to offer planning or technical assistance might have helped increase the applicant pool by assisting entities through the process of accreditation. The Committee recognizes that HHS lacks the legislative authority to make the needed changes to this program. To the extent possible, the Secretary may want to pursue using other funding or technical assistance mechanisms to help potential applicants through the accreditation process so they can expand the applicant pool. The committee recommends that the Secretary, under Section 301 of the Public Service Act, conduct a demonstration project to identify the most effective ways to expand the number of accredited community based primary care residency programs.

## **CONCLUSION**

The Committee strongly believes that the successful retention of primary care practitioners in rural communities is contingent on the ability to expand rural training opportunities and use new recruitment strategies, while also strengthening existing programs such as the NHSC. Rural primary care is a unique discipline with its own challenges reflective of the community it serves. Unfortunately, our current workforce training and placement system does not always serve the needs of rural communities well. The ACA has given HHS tools to change this dynamic in terms of both training and distribution. Positive experiences with the NHSC, as well as with rural residency programs, will likely determine whether a primary care practitioner chooses to serve in a rural community beyond the time of their service or training period. Also, successful and satisfying experiences are relayed in the information passed back to potential NHSC scholarship and loan replacement candidates, helping to encourage them to participate. It is the hope of this Committee that the recommendations, if implemented effectively, will help increase the long-term retention of rural primary care practitioners, and facilitate a more equitable distribution of medical resources in our country.