U.S. Senate Committee on Finance

Committee Hearing

Rural Health Care:

Supporting Lives and Improving Communities

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Written Testimony

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Chairman Wyden, Ranking Member Crapo, and Members of the Committee:

My name is Lori Rodefeld and I serve as the Director of GME Development for the Wisconsin Collaborative for Rural Graduate Medical Education (WCRGME) a program of the Rural Wisconsin Health Cooperative. In addition to this role, I serve as the Director of GME Development for the Rural Residency Planning and Development (RRPD) and Teaching Health Center Planning and Development (THCPD) Technical Assistance Centers. I have been engaged in rural workforce development for nearly 20 years working at a technical college, a rural hospital, and now in support of growing the physician workforce not only in Wisconsin but in rural communities across the country. Living in rural Wisconsin, I see firsthand the shortages within our healthcare system and how it impacts access to care with fewer healthcare professionals available to fill critical positions.

The issues facing rural health workforce are complex and I will not have time during my testimony to cover all issues and potential solutions. My focus will be on the shortage of healthcare professionals in rural areas and how policy can help address this issue leaning on my experience with rural physician workforce strategies.

To address the shortage of rural healthcare professionals, action must be taken including:

- Foster the expansion of rural residency training through policy that supports growth and sustainability for this successful model of training.
- Develop strategies that bolster expansion of rural training for other health professionals including nurses, physician assistants, pharmacists, dentists, medical assistants, laboratory technicians, physical therapists, social workers, and others.
- Explore ways to amplify local and state level efforts to innovate and develop programs to expand training that will address shortages of healthcare professionals through the development of partnerships.

Workforce is the Top Issue Facing Rural Healthcare Organizations

Rural healthcare has long faced challenges in recruiting and retaining qualified physicians and other healthcare professionals.[i] This isn't just an inconvenience – it threatens the fabric of healthcare in rural communities. An aging workforce combined with a declining younger populations to assume these positions could lead to a crisis within rural healthcare. The hospitals and healthcare facilities in my state of Wisconsin are already stretched thin, serving patients around the clock to meet their community's needs. Unlike other industries, their hours can't be scaled back. Emergency rooms, trauma centers, inpatient services, and labor and delivery units – these critical services rely on a strong, stable workforce to keep the doors open.

My testimony will not only include examples from Wisconsin, but also a national perspective as we look to strategies that will address rural workforce shortages. I'll work to highlight innovative approaches as we explore ways to support not only rural physician training but also

the training of other health professionals. The extensive research in rural medical education offers insights that can be applied across healthcare professions.

Rural Residency Training Provides a Successful Framework to Build Upon

To address the doctor shortage in rural areas, the answer is clear: invest in rurally-based GME training. It's a proven strategy that has been in place for decades. Unfortunately the growth in rural training has not kept pace with the growth of GME as a whole. It's estimated that only 2% of residency training takes place in rural communities[ii] despite nearly 20% of the population living in a rural community.[iii]

A common misconception is that rural hospitals can't participate in GME programs due to lack of interest, infrastructure, volume, or experience which simply isn't true. Efforts to grow rural residency training have emerged not only in my home state of Wisconsin but across the country. High quality training has developed in a number of hospitals ranging from larger sole community hospitals with multiple programs to smaller critical access hospitals hosting family medicine residency programs to community health centers launching psychiatry residency programs.

For years the state of Wisconsin was impacted by the closure of five rural track programs (RTPs) which were launched as partnerships between larger urban hospitals and rural hospitals. Working to overcome this loss in the training of rural doctors, the state launched a GME program development grant which served a catalyst for growth of new programs. Hospitals were eligible to receive up to $750,000 in support of planning and infrastructure development to host an accredited residency program. One of the first hospitals to take advantage of this funding was the SSM Monroe Hospital who launched the first new family medicine residency in Wisconsin in nearly two decades. SSM Monroe has seen success with nearly 50% of its graduates retained within the health system, a majority of graduates practicing in rural and underserved areas, and over 90% of the graduates have remaining in the state of Wisconsin.

The success of the RRPD program is another example of the growing interest by rural hospitals in creating new GME programs. Administered by HRSA, within the US Department of Health and Human Services, this program offers crucial start-up funding and technical assistance to launch GME programs within rural health facilities. Forty-six new rural residency programs have achieved accreditation by the Accreditation Council for Graduate Medical Education (ACGME). These programs translate to a significant increase in physician training opportunities, with 575 approved resident positions at full capacity. This includes 441 positions in family medicine, 68 in psychiatry, 51 in internal medicine, and 15 in general surgery.[iv]

Growing the Rural Physician Workforce Requires Both State and Federal Level Support

The shortage of rural physicians has been an ongoing issue not only in Wisconsin but across the country as stakeholders are taking action to address these critical health disparities. There is a growing body of evidence showing that training in rural places leads to practice in rural places.

Recent studies have demonstrate physicians who complete at least half of their GME in rural areas are 5 times more likely to practice in rural areas versus those without rural training.[v]

Interest by rural facilities in creating GME experiences continues to grow. In Wisconsin, there are 27 rural programs which is an increase from 6 rural programs in 2012. The state has over 30 established rural rotations with continued interest by rural hospitals, clinics, and health centers in serving as a rotation or GME site. There are currently 7 new GME programs under development in Wisconsin with interest from additional sites. Additionally, the Rural Residency Planning and Development (RRPD) Technical Assistance Center has identified 145 hospitals GME naïve hospitals in rural communities with characteristics and volumes similar to established teaching hospitals that could be strong candidates for future development.[vi]

The Consolidated Appropriations Act (CAA) of 2021 aimed to address the critical shortage of rural physicians at the federal level, with three key sections related to rural GME. Under Section 126, 10% of new residency slots were to be allocated to rural hospitals and data shows the majority of these slots were not distributed to geographically rural hospitals.[vii,viii] In Wisconsin, Marshfield Clinic did not receive slots under section 126 for its internal medicine residency program in the first two rounds of distributions despite being geographically rural. Other rural hospitals have not applied for slots because they do not have a Health Professionals Shortage Area (HPSA) designation.

Under section 127 of the CAA, a complex separate accreditation requirement was removed allowing for the expansion of existing accredited programs through a permanent complement increase and FTE cap increase allowing for the creation of new rural positions.[ix] This legislation has allowed hospitals interested in rural GME the opportunity to create new positions with reduced startup costs and less administrative expenses that can be associated with separate accreditation. This has led to the creation of new rural residency programs including two new programs at Creighton in psychiatry and internal medicine[x] as well as a psychiatry residency at West Virginia University.[xi]

Section 131 of the CAA provided a one-time opportunity for certain hospitals to reset their Medicare reimbursement rates for graduate medical education.[ix] This was specifically aimed at hospitals with low FTE (full-time equivalent) resident caps or Per Resident Amount (PRA) figures. The timeframe for this reset will expire on December 26th, 2025.

Expanding rural rotations offers a promising strategy to strengthen the rural physician workforce.[xii] This approach shifts residents' training into rural sites providing diverse training experiences outside of programs in larger communities. Additionally, rural rotations are less resource-intensive making them a more accessible entry point for building academic-rural partnerships while also creating a solid foundation for future GME growth. Section 131 allows for residents to rotate at rural hospitals for up to 1.0 FTE without triggering a FTE cap.[ix]

Wisconsin stands as a leader in supporting state-level GME growth, particularly in rural communities. Collaboration between several key stakeholders including the Wisconsin Hospital Association, Wisconsin Council on Medical Education and Workforce, the Rural Wisconsin Health Cooperative, medical schools, and existing GME programs, has allowed for the creation of an ecosystem to train future rural physicians. State level GME funding has yielded impressive results. Hospitals looking to develop new programs or expand existing programs have helped support an increase of over 60 additional resident positions each year[xiii] and over 20 new programs in high need specialties including family medicine, psychiatry, general surgery, and obstetrics and gynecology. In the last legislative session, support for increased funding per slot and removal of caps were approved with strong support. Both Medicare and Medicaid funding combined with state appropriations have been essential to grow our workforce.

Beyond Wisconsin, there are 44 other states developing strategies to utilize Medicaid GME funding as an investment in physician workforce.[xiv] Some states are focused on growing or supporting positions in rural or high need specialty areas. Medicaid GME allows for states to address maldistribution of physicians by geography, specialty, setting, or by responding to population growth.[xv] Approaches vary significantly with some states providing supplemental funds, allocating additional GME slots, supporting planning and development, or offering technical assistance. There is an opportunity to create new learnings across states and share approaches as a way to developing and sustaining residency programs that will meet our population health needs.

Opportunities to Bolster Training of Other Health Professionals

With the demonstrated success of expanding rural physician training as a workforce strategy, there's an opportunity to apply these learnings to other health professions. Evidence shows that one of the factors most closely associated with health care professionals choosing to practice in a rural area is being raised in a rural area.[xvi] Therefore, strategies to engage a pipeline of rural students and providing rural experiences are vital to addressing rural workforce shortages. In Wisconsin and other states, efforts are underway to provide resources and support specifically for training other health professionals. These initiatives range from state grants and funding to collaborative partnerships which further develop our future rural workforce.

One such initiative is a Wisconsin state grant program launched in 2017.[xvii] This program supports the development of training opportunities for allied health professionals giving a preference for those in rural areas. Hospitals and healthcare facilities can receive up to $125,000 in funding to support the expansion of training healthcare professionals in their facilities who provide direct patient care and has supported education for a number of students including those training to become behavioral health specialists, counselors, laboratory technicians, and other critical healthcare professions. Since its implementation, this program

has funded the establishment of 50 educational partnerships, allowing for a significant expansion of clinical training sites, primarily in rural areas.

This approach is echoed in Minnesota's innovative Medical Education and Research Costs (MERC) program. Established in 1996, MERC uses Medicaid funding to support training not just for physicians, but also for other crucial health professionals in their state.[xviii] The program has continually adapted, expanding eligibility in 2013 to encompass training programs for social workers, community health workers, paramedics, dental therapists, and psychologists. Similarly, the state of Washington is exploring using Medicaid funds to support training for Advanced Practice Providers, aiming to increase the number of primary care and behavioral health providers in rural and underserved areas.[xix]

These efforts, coupled with initiatives that spark early interest in healthcare careers among rural youth, offer a promising path towards a more robust rural healthcare workforce. Attracting middle or high school students, especially those in rural communities, is essential. Many rural hospitals in Wisconsin have invested in programs like "club scrub," youth apprenticeships, and even a health careers high school. The Rural Wisconsin Health Cooperative is developing an interactive computer game to allow students to explore rural health careers, increasing awareness and interest in the vast options available.[xx]

Wisconsin's technical colleges are playing a key role as well. One example is the "Need for Nurses" program at Southwest Technical College.[xxi] Partnering with six rural hospitals, this program secured funding to double its enrollment and offer nursing degrees in both fall and spring semesters. The public-private partnership goes beyond program costs; it's an investment in student success, promoting continuous enrollment, retention, and completion.

Recruitment of Medical Assistants (MAs) in Wisconsin is an issue not only for rural hospitals but also rural health centers. Recognizing that training can occur in an academic institution or through an apprenticeship model, community health centers have worked to develop their own training program providing virtual instruction shared amongst health centers with hands-on learning occurring at local centers.[xxii] This centralized model allows for leveraging of shared resources while giving students an opportunity to “earn while they learn.” MA positions are unique as they allow for further career growth as they can later pursue other health careers including nursing, pharmacy, or medicine.[xxii]

Finally, I would like to highlight an example of rural innovation at Gundersen's Hillsboro Hospital. They recognized the critical need for mental health services in their local schools and established a partnership with a nearby college to create a solution by bringing social work (LCSW) students into their local schools.[xxiii] These students gain invaluable clinical experience working directly in the schools allowing students to fulfill their licensure requirements while also providing much-needed mental healthcare to students, fostering a healthier learning environment.

Despite Progress Made to Grow Rural Workforce, Challenges Remain

Despite federal and state efforts to increase the number of residency positions, significant challenges remain for rural hospitals looking to develop or sustain rural residency programs. Primary challenges include the cost to develop a program, Medicare funding complexities, varied definitions of rural, limited timeline to reset a FTE cap or PRA, and financial uncertainty for the Teaching Health Center Graduate Medical Education (THCGME) program.

Financing to support and sustain a residency program can serve as a barrier to expanding GME in rural areas. For hospitals looking to launch a new program, the initial investment can be substantial. The cost to develop a residency program in a rural hospital has not been studied extensively; however, new programs in Wisconsin are seeing financial estimates of over $2 million dollars to launch a smaller size 6 resident family medicine residency program. Federal grant support like the RRPD program or state grants like those developed in Wisconsin can help offset the initial upfront costs in launching a new GME program.

As programs develop, there are challenges associated with starting a program which include funding inequities based on hospital type. Certain rural hospital payment methodologies do not result in full Medicare GME funding for Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs). Financial projections estimate reductions in indirect medical education (IME) payments based on Medicare Advantage utilization. Allowing full IME payments for these hospitals or treating SCHs or MDHs as non-hospital sites in a manner similar to the payment models for Critical Access Hospitals could be potential policy solutions.

While the Consolidated Appropriations Act has included provisions in support of rural GME expansion, there are opportunities to further support rural hospitals. The FTE Cap and/or PRA reset deadline under Section 131 will sunset in December 2025. While some hospitals have utilized this opportunity, others have struggled with accreditation and/or necessary program partnerships to take on training of residents in order to reset low FTEs and PRAs. A policy solution could include an extension of the deadline for FTE Cap and/or PRA resets allow additional time for impacted hospitals. Policy could also be considered to broaden the ability of rural programs to grow further by allowing a hospital in a geographically rural area with less than 12 FTEs to reset a FTE cap or PRA at any time which would allow for more substantial growth beyond the additional slots offered through Section 126.

Current limitations on the definition of "rural" are hindering the growth of GME programs in Wisconsin and across the country. The Centers for Medicare and Medicaid Services (CMS) uses a metropolitan or non-metropolitan county designation to authorize payment for funding of GME programs. An alternative may be to consider using the Federal Office of Rural Health Policy (FORHP) definition which looks at additional variables like census tracts in addition to non-metropolitan areas. The CMS definition has excluded hospitals in Wisconsin which meet the FORHP definition from participating in Rural Track Programs (RTPs). Transitioning to a new definition would broaden the pool of hospitals eligible to create RTPs especially in western

states with geographically large counties. This would benefit not only urban residency programs eager to partner with rural hospitals but also rural hospitals interested in developing GME programs who are currently ineligible due to CMS's stricter definition.

HRSA administers programs to provide funding to support education in rural and underserved settings. The THCGME program supports 81 residency programs which include 30% who train residents in rural communities. The THCPD Program supports the startup of 93 new THCGME programs expanding this reach even further.[xxiv] One example of a THCPD program making an impact is the Marshall University Consortium Rural Psychiatry Program which recently received ACGME approval and has already recruited 4 residents to join the program this year. The program will provide psychiatry services to a rural county in West Virginia that currently has no psychiatrists. Marshall faculty are filling this void and providing access to a community that desperately is in need of psychiatrists. There is not a current THCGME funding opportunity for THCPD grantees who are committed to training doctors and dentists in rural and underserved areas.

To impact health workforce, grants and support for development of local or state level clinical training infrastructure through technical assistance could help rural healthcare entities expand their training capabilities. Building on the success of other technical assistance center models, consideration could be given to develop assistance for states looking to further develop their own strategies utilizing public-private partnerships or Medicaid GME support to further build their workforce in rural communities and shortage areas. An organization working to support identification of best practices and innovations would ensure rural health pipeline successes are shared and can be replicated. State-based efforts have proven to be an effective strategy through bringing together key stakeholders to identify specific workforce needs in a responsive manner.

Although state level efforts can make an impact, federal funding models should be explored to help rural communities expand clinical training in a variety of health professions with career pathway models to support progression within health professions. Additionally, support for rural middle and high school students in career pathways and skill development is critical as a strategy to build our future rural health workforce. Resources are needed to help build infrastructure, develop partnerships, and support training site development.

Conclusion

Thank you Chairman Wyden, Ranking Member Crapo, and members of the Senate Committee on Finance, for the opportunity to testify today regarding rural health workforce. The future of rural healthcare depends on our ability to cultivate a strong workforce. It is an honor to share the successes we have seen in Wisconsin and across the nation in supporting rural residency development as a framework to further promote rural health careers across all health professions. With continued investment and policy development, we can work to build a pipeline of talented healthcare professionals who are interested and prepared to serve in rural

communities. Federal policy can serve as a catalyst for building upon the work already underway in support of rural healthcare.

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