

## **Bipartisan Medicare GME Working Group Draft Proposal Outline and Questions for Consideration**

The Medicare program invests in the residency training of physicians through Medicare graduate medical education (GME) payments. Medicare GME payments are made to eligible teaching hospitals, which have accredited residency programs in medicine, osteopathy, dentistry, or podiatry. Medicare GME covers the Medicare share of a residency program through direct payments and indirect payments. Direct GME (DGME) payments are aggregate payments to a hospital and cover costs such as a resident's stipend and supervising physician's salary. Indirect GME (IME) payments are add-on payments that cover the higher costs to a teaching hospital associated with training a resident, such as ordering additional medical tests or otherwise providing less efficient health care.

Due to a concern that there was an oversupply of physicians, Congress capped the amount of Medicare GME funding a teaching hospital could receive based on the number of residents a hospital was training in 1996. Nearly thirty years later, it has become clear that there are not enough physicians to meet the health care needs of Americans. According to HRSA, there will be a shortage of 139,940 physicians across all specialties by 2036, with a projected shortage of 68,020 primary care doctors and 42,130 psychiatrists over the same time frame.<sup>1</sup> Congress can act to address these shortages by increasing the number of Medicare-supported residency positions in teaching hospitals. In addition, federal Medicare GME legislation can address the disproportionate shortage of physicians in certain specialties, including primary care and psychiatry, and in certain geographic locations, such as rural and underserved communities. Finally, improvements to federal Medicare GME data collection can improve the use of this program to sustain the health care workforce long-term.

As a bipartisan group of members of the Senate Finance Committee, which has jurisdiction over the Medicare GME program, we are interested in advancing additional Medicare GME proposals to address health care workforce shortages and gaps. This document outlines a draft policy proposal and specific questions for consideration on policies under consideration related to the Medicare GME program. We are also interested in feedback on additional policy proposals we may have overlooked with respect to addressing workforce shortages and improving the distribution of workers to rural and underserved areas within the Medicare GME program.

As with other policy proposals considered by the Senate Finance Committee, we intend to separately identify appropriate offsets that will pay for the cost of new Medicare GME policies.

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<sup>1</sup> Health Workforce Projections, Health Resources and Services Administration, March 2024, available at <https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand#:~:text=Since%20it%20can%20take%20over,overall%20shortage%20of%20139%2C940%20physicians>

## **SECTION 1. Short Title**

## **SECTION 2. Additional and Improved Distribution of Medicare GME Slots to Rural Areas and Key Specialties in Shortage**

**Background:** Congress has enacted legislation to increase the number of Medicare-supported residency positions, also called GME “slots”, at eligible teaching hospitals in order to address the shortage of physicians. Over the past 4 years, Congress added 1,200 new Medicare GME slots. In the Consolidated Appropriations Act, 2021 (CAA, 2021), Congress added 1,000 new Medicare GME slots, and in the Consolidated Appropriations Act, 2023 (CAA, 2023), Congress added 200 new Medicare GME slots. These bills required the Centers for Medicare and Medicaid Services (CMS) to distribute specific percentages of these slots to hospitals in rural areas, hospitals training a number of residents beyond their Medicare GME cap, hospitals in states with new medical schools, and hospitals located in health professional shortage areas (HPSAs). We have heard concerns from stakeholders that there is a need to add additional Medicare GME slots to address projected physician shortages, to better target these slots toward rural areas and key specialties in shortage, and to improve the retention of physicians in rural and underserved communities.

### **Summary:**

- This provision would add additional Medicare GME slots from fiscal year (FY) 2027 through FY 2031. This provision currently does not specify the number of additional slots.
- This provision distributes at least 25% of new Medicare GME slots toward primary care residencies and at least 15% of new Medicare GME slots toward psychiatry or psychiatry subspecialty residencies to address the disproportionate shortage of primary care physicians and psychiatrists. These percentages are bracketed.
- Hospitals that receive new psychiatry or primary care slots must maintain these slots for a period of 10 years. If the Secretary of the Department of Health and Human Services (HHS) determines that a hospital does not meet these requirements, then the Secretary is directed to redistribute the slots to other hospitals for primary care and psychiatry residencies.
- This provision would distribute new Medicare GME slots based on a formula that amends the GME allocation formula enacted in the CAA, 2023 in order to improve distribution of slots to rural areas. Specifically, this provision would change the definition of rural hospitals to:
  - Exclude hospitals that are treated as being located in a rural area.
  - Include hospitals located in a rural area, hospitals located in an area with a rural-urban commuting code equal to or greater than 4.0, sole community hospitals, and hospitals located within 10 miles of a sole community hospital.

- This provision would direct the HHS Secretary to prioritize new Medicare GME slots for hospitals that are affiliated with a center of excellence, a historically black college or university (HBCU), or other minority serving institution (MSI) that establishes a medical college in order recruit physicians who are more likely to work in a rural or underserved community long-term.
- This provision would limit the number of new Medicare GME slots that a hospital can receive under this provision to 10. This provision brackets this limit.
- This provision would maintain other aspects of the GME allocation formula enacted in the CAA, 2023.

### **Questions for Consideration**

- How many additional Medicare GME slots are needed to address the projected shortage of physicians?
- To address the disproportionate shortage of primary care doctors and psychiatrists, what percentage of new Medicare GME slots should be dedicated toward these two specialties? What additional Medicare GME policies should Congress consider to encourage more residents to enter these specialties?
- Would the proposed changes to the definition of rural hospitals in the CAA, 2023 GME allocation formula outlined above improve the distribution of slots to rural communities?
- Beyond the proposed changes to the definition of rural hospitals, is it necessary to provide further clarification in the existing statute to ensure that CMS allocates GME slots to particular categories as specified in the CAA, 2023 GME allocation formula?
- How should Congress approach the role of hospitals which engage in “rural reclassification,” wherein a hospital changes its designation from urban to rural, then back to urban within one calendar year for the purposes of receiving Medicare GME payment?
- How could Congress improve the recruitment of physicians to work in rural or underserved communities? For example, would adding criteria to allocate GME slots for hospitals affiliated with centers of excellence, HBCUs, or MSIs and for hospitals affiliated with non-academic hospital settings improve the distribution of physician training and recruitment in rural and underserved areas?
- Would increasing the cap for hospitals in states with the lowest number of GME slots, rather than for all hospitals, improve distribution of GME slots to areas with workforce shortages?
- How can Congress help incentivize Medicare GME in Indian Health Service facilities?

### **SECTION 3. Encouraging Hospitals to Train Physicians in Rural Areas**

**Background:** We have heard concerns that rural hospitals lack the resources to set up the infrastructure needed to establish residency training programs. Sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs) serve rural communities and are well suited to

establish residency training programs to recruit and retain physicians. Unfortunately, SCHs and MDHs only receive Medicare DGME payments, and they do not all receive IME payments. This puts rural hospitals at a disadvantage for establishing or supporting residency programs. We have also heard concerns that rural hospitals are unaware of the opportunity to apply for new Medicare GME slots, a percentage of which are intended to be directed toward hospitals in rural communities. Finally, stakeholders have benefited from telehealth flexibilities that allow teaching physicians to use audio/video real-time communications technology to supervise the training of resident physicians. This flexibility can be an important tool for rural hospitals to expand their ability to train physicians in specialties that do not involve interventional or high-risk procedures. CMS is exercising enforcement discretion for teaching physicians who use this flexibility through the end of 2024.

### **Summary:**

- This provision would allow additional sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs) to receive IME payments to support the cost of training residents in rural communities.
- This provision would extend the ability of teaching physicians to use telehealth to supervise resident physicians beyond December 31, 2024.

### **Questions for Consideration**

- What barriers exist for hospitals in rural and underserved areas to launch new residency programs supported by Medicare GME?
- What revisions to IME payment are needed in order to improve financial support for rural hospitals interested in establishing residency training programs, or otherwise improve the Medicare GME program to support rural hospitals?
- What programs under the jurisdiction of the Senate Finance Committee can provide targeted outreach and technical assistance to rural hospitals so they can apply for Medicare GME slots?
- Should guardrails be put in place to ensure patient outcomes and a resident's educational experience are not negatively impacted by an extension of flexibilities that allow teaching physicians to use telehealth to train resident physicians?
- What other telehealth flexibilities should the working group consider that would benefit resident physicians who are being trained in teaching hospitals, particularly those located in rural or underserved areas?
- What additional incentives could be provided to hospitals to partner with rural hospitals or ambulatory care facilities to establish residency programs supported by Medicare GME?
- How can existing rural track programs be strengthened and expanded through Medicare GME?

## **SECTION 4. Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage**

**Background:** We have heard concerns that the Medicare GME program does not have a mechanism to support residencies that are projected to be in shortage. While Congress can direct CMS to allocate a specific percentage of GME slots toward certain specialties, there should be a better mechanism to distribute slots to specialties in shortage that does not require Congressional action.

**Summary:** This provision would direct the HHS Secretary to establish a time-limited GME Policy Council consisting of 9 members representing academic medical institutions, hospitals that serve rural areas and underserved communities, medical students, and health care workforce experts. This GME Policy Council will be required to evaluate the distribution of new Medicare GME slots made available under this bill. The GME Council will make recommendations to the HHS Secretary regarding the distribution of the new Medicare GME slots added by this bill to rural areas and specific medical specialties, in addition to the slots that are dedicated for primary care and psychiatry.

### **Questions for Consideration**

- Should Congress include additional specifications for a GME Policy Council in order to improve its success in allocating GME slots to physician specialties projected to be in shortage?
- Does the existing Council on Graduate Medical Education (COGME), a federal advisory committee that assesses physician workforce trends, fulfill the goals of this new Medicare GME Policy Council? How can Congress enhance the work of the COGME?

## **SECTION 5. Improvements to Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs**

**Background:** The Consolidated Appropriations Act, 2021 (CAA, 2021) gives certain hospitals 5 years to build up their residency programs so they can reset their low GME caps and expand the number of residents they train. We have heard concerns that hospitals may need more time to build up these residency programs.

**Summary:** This provision would amend the provision of the CAA, 2021 that resets the low GME caps of certain hospitals. Specifically, the provision would provide 10 years rather than 5 years for eligible hospitals to establish a new per resident amount (PRA) or residency full-time equivalent (FTE) cap. This provision would also provide a statutory fix for certain hospitals that have had low PRA or FTE caps for a period of 20 cost reporting periods.

### Questions for Consideration

- How much time do hospitals with low GME caps need to reset their caps?
- Should additional hospitals be eligible to reset their low GME caps? What should be the eligibility criteria of these additional hospitals?

## SECTION 6. Improvements to the Distribution of Resident Slots Under the Medicare Program after a Hospital Closes

**Background:** Under current law, if a hospital with an approved medical residency program closes, CMS must redistribute the hospital's residency positions to other hospitals in the following order: (1) hospitals in the same core-based statistical area as the closed hospital, (2) hospitals in the same state as the closed hospital, (3) hospitals in the same region of the country as the closed hospital, and (4) other remaining hospitals. In order to receive the additional positions, hospitals must demonstrate a likelihood of filling the positions within three years. We have heard concerns that the current process for redistributing these slots prioritizes regions of the country that would not benefit the most from additional Medicare GME slots.

**Summary:** This provision would amend the current process for distributing GME slots from hospitals that close their residency programs. This provision keeps the requirement that CMS first distribute slots to hospitals in the same core-based statistical area and state as the closed hospital. However, this provision removes the requirement that CMS prioritize hospitals in the same region of the country as the closed hospital when distributing slots from these closed hospitals in order to expand the reach of these newly available slots. This provision also requires hospitals to demonstrate a likelihood of starting to use these positions within 2 years and to fill the positions within 5 years.

### Questions for Consideration

- Would the proposed changes to the formula for redistributing slots from closed hospitals improve the distribution of GME slots to regions of the country facing greater physician shortages?
- What additional policies should Congress consider to improve the distribution of unused GME slots to areas facing the greatest projected shortage of physicians?

## SECTION 7. Improving GME Data Collection and Transparency

**Background:** We have heard concerns that there is a lack of accountability in the Medicare GME program. There is no method to track the specialties of physicians that are supported by Medicare GME payments, and there is no mechanism to track where these physicians end up

practicing. Instead, researchers depend on estimates of payments and the number of physicians who are trained by analyzing Medicare cost reports. We have also heard concerns that it is difficult to determine the amount of Medicare DGME and IME payments a teaching hospital receives and how hospitals are using these payments to invest in training the physician workforce. Finally, we have heard concerns that there is a lack of alignment in reporting requirements across federal GME programs.

### **Summary:**

- This provision would require the HHS Secretary, in consultation with the Secretary of the Department of Veterans Affairs (VA), to submit an annual report to Congress and make a publicly available database on federal GME programs, including Medicare GME, the Department of Defense (DOD) GME, and Medicaid GME.
- This provision requires teaching hospitals to report the following information:
  - The number, specialty type, diversity, and citizenship information of residents supported and who completed their residency under each federal GME program.
  - The amount of Medicare direct GME (DGME), including the per resident amounts, and indirect medical education (IME) payment that a teaching hospital receives.
  - The amount that a teaching hospital spends on training residents, including through direct costs like resident stipends and supervising physician salaries, and indirect costs, broken down by each year of a resident’s training.
  - The number and percentage of residents by specialty type who completed their residency and entered practice in a HPSA or rural area.
  - The number and percentage of residents retained in the practice of primary care at least two years after the completion of their residency.
  - The amount of GME payment, broken out by DGME and IME payment amounts, provided by residency type or specialty and site of training.
  - The number of residents who experienced remediation, probation, transfers, withdrawals, or dismissals, broken out based on gender and race or ethnicity.
- This provision would require HHS to calculate Medicare GME slots/100,000 residents by state and projected physician shortages by state, and assess how Medicare GME investments address these projected shortages.
- This provision would require the HHS Secretary to use existing data collected for other purposes to carry out this provision and to minimize administrative and reporting burdens.

### **Questions for Consideration**

- What information do teaching hospitals already report on the “outcomes” of their residency programs, and where is this information reported?

- What additional information should teaching hospitals report, in addition to what is proposed above, in order to improve accountability of federal GME investments?
- What additional data does Congress need to collect in order to determine whether DGME and IME payment rates appropriately match the cost of training residents? For example, what data does Congress need in order to determine whether payment rates for GME funding can be calculated by methods that are not focused on Medicare beneficiary inpatient bed-days?
- It is of interest to track whether residents trained in primary care continue to practice in this specialty because primary care training is frequently a precursor to other residency training. Are there other specialties that teaching hospitals should similarly report?