Draft Medicare GME Reform Package

Section-By-Section

Section 1. Short Title.

Section 2. Additional Distribution of Medicare GME Residency Positions to Rural Areas and Key Specialties in Shortage

From FY2027 through FY2031, [5,000] additional Medicare GME residency positions (slots) will be added. These slots will be allocated with at least 15% dedicated to psychiatry or psychiatry subspecialties and 25% allocated to primary care. After FY2031, every five years, HHS will consider recommendations from the newly established GME Policy Council to determine appropriate percentages for psychiatry, primary care, or other specialties.

Hospitals must demonstrate the likelihood of filling new residency positions within 5 years to receive these additional slots. Furthermore, 10% of the new slots will be reserved for hospitals in each of the following categories: (1) redefined rural hospitals, (2) hospitals training more residents than their GME cap allows, (3) hospitals in states with new medical schools or branch campuses, and (4) hospitals serving health professional shortage areas (HPSAs).

HHS will distribute slots according to the statutory formula, with priority given to hospitals in rural and underserved areas. This section directs HHS to prioritize distribution to hospitals that serve rural and underserved areas. Specifically, this provision directs HHS to prioritize awarding of slots toward hospitals located in states with a lower ratio of medical residents per 100,000 population, located in a medically underserved area, or are affiliated with an eligible historically Black college or university (HBCU) or other minority serving institution that establishes a medical college.

The number of slots an individual hospital can receive will be capped at 30. This provision is bracketed.

This section would apply a national standard per resident amount (PRA) for new direct GME payments (DGME) that a hospital receives under this bill. This standard PRA would not apply to a hospital's existing Medicare GME slots. This per-resident amount will be calculated from the national weighted average PRA amount, then adjusted through cumulative bonuses for hospitals with high dual eligible populations, in states with primary care shortages, in geographic HPSAs, or who qualify as a high expense hospital. HHS must establish this new formula through notice and comment rulemaking. The new PRA methodology does not impact any existing or previously allocated GME slot. This provision is bracketed.

This provision also maintains the current structure for Indirect Medical Education (IME) payments, with no changes to IME calculation.

This section would also allow academic medical centers to use IHS, Tribal facilities, and Urban Indian Organizations (I/T/U) facilities as a training site, as critical access hospitals (CAHs) are

allowed to be used. This would consider time spent at I/T/U facilities as time spent at "non-provider" sites, similar to CAHs.

Section 3. Encouraging Hospitals to Train in Rural Areas

This section addresses the challenges rural hospitals face in supporting residency programs. Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs) currently receive Medicare Direct GME (DGME) payments, but not all receive Indirect Medical Education (IME) payments, which puts them at a disadvantage. This provision allows additional SCHs and MDHs to receive IME payments to support the cost of training residents in rural areas.

Telehealth flexibilities allow teaching physicians to use real-time audio and video technology to supervise residents, particularly in specialties not requiring interventional or high-risk procedures. This provision extends this telehealth flexibility beyond January 1, 2026, for teaching physicians, ensuring they can continue supervising resident physicians remotely.

The provision also expands the Medicare Rural Hospital Flexibility Program to include all rural hospitals (not just CAHs). This program will conduct outreach to rural hospitals, inform them about eligibility for rural Medicare GME slots, and assist them in the application process. A mandatory appropriation will fund these activities, supporting rural hospitals in applying for and securing Medicare GME slots.

Section 4. Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage

This section creates a new Medicare Graduate Medical Education (GME) Policy Council with 13 members appointed by HHS, based on recommendations from the Government Accountability Office (GAO). The members must include representatives from academic medical institutions (including one MD and one DO school), hospitals serving rural and underserved areas, medical students, healthcare workforce experts, and at least one MD and one DO.

The Council will advise the HHS Secretary on the distribution of GME positions in areas and specialties projected to experience physician shortages after fiscal year 2032 and every five years thereafter. The Council will also recommend a measure to track how many physicians from teaching programs work in health professional shortage areas or medically underserved areas, and for how long. Additionally, the Council will help develop an application process for hospitals with low FTE caps to request unallocated GME positions after fiscal year 2031.

The Council will collaborate with the Council on Graduate Medical Education to carry out its duties.

Section 5. Improvements to Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs

The 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. This provision would amend this provision of the CAA, 2021 to provide these hospitals an unlimited amount of time to establish a new per resident amount (PRA) or residency full-time equivalent (FTE) cap.

Section 6. Improvements to the Distribution of Resident Slots under the Medicare Program After a Hospital Closes

This section changes how GME slots are redistributed when a hospital closes its residency program. Currently, CMS redistributes residency positions in this order: (1) hospitals in the same core-based statistical area as the closed hospital, (2) hospitals in the same state, (3) hospitals in the same region, and (4) remaining hospitals. Hospitals must prove they can fill the positions within three years.

This section keeps the priority for hospitals in the same core-based statistical area and state, but removes the regional priority to broaden the distribution of available slots. It also shortens the time frame for hospitals to demonstrate they can start using the positions within 2 years and fill them within 5 years.

Section 7. Improving GME Data Collection and Transparency

This section directs CMS to publicly report information on federal GME programs, including:

- Indirect medical education and direct graduate medical education costs;

- Number, specialty type, licensure type, gender, race or ethnicity, and citizenship information of residents supported;

- Number and percentage of residents supported, by specialty type, who completed their residency training and entered practice primarily serving a health professional shortage area, medically underserved area, or a rural area;

- Number and percentage of residents supported who were retained in the practice of primary care at least two years post initial residency completion to account for further specialization;

- The aggregate graduate medical education payment amounts provided by residency type or specialty and site of training; and

- Number of residents who experienced remediation, probation, transfers, withdrawals, or dismissals, broken out based on gender and race or ethnicity, on an aggregated basis to protect privacy.

CMS must utilize existing data collected through Medicare Cost Reports and through other entities in order to minimize the administrative burden of reporting this information. CMS must also publish this information in a public use data file that is easy to use by researchers, policymakers, and the public.