Senate Finance Releases Proposal To Increase Medicare GME Slots

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(Inside Health Policy)

A bipartisan group of six Senate Finance Committee members are asking for stakeholder feedback on a policy outline that calls for increasing by an unspecified amount Medicare graduate medical education slots, encouraging hospitals to train physicians in rural areas, creating a temporary council to improve the distribution of GME slots and improving data collection and transparency, among other things.

The policy outline does not include potential payfors; "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."

Chair Ron Wyden (D-OR) and ranking Republican Bill Cassidy (LA) led four of their colleagues in unveiling the seven-part proposal Friday (May 24) with the goal of addressing health care workforce shortages and gaps.

"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," the senators say. "Nearly thirty years later, it has become clear that there are not enough physicians to meet the health care needs of Americans."

Specifically, the senators want to add additional Medicare GME slots from fiscal 2027 through 2031 and distribute the unspecified amount with at least 25% going to primary care residencies and a minimum of 15% for psychiatry or psychiatry subspecialty residencies. The funds would be distributed under a tweaked GME formula that would change the definition of rural hospitals.

Hospitals that receive these new slots would be required under the proposal to keep them for ten years. Senators plan to direct HHS to prioritize these new slots for hospitals affiliated with a center of excellence, a historically black college or university, or other minority serving institution that creates a medical college that recruits physicians who are more likely to work in a rural or underserved community long-term.

The policy outline includes a provision to let more sole community hospitals and Medicare-dependent hospitals receive indirect GME payments and extend the ability of teaching physicians to use telehealth to supervise resident physicians beyond Dec. 31.

Senators also want to create a time-limited GME Policy Council consisting of nine members who represent academic medical institutions, hospitals that serve rural areas

and underserved communities, medical students, and health care workforce experts. The council would evaluate the distribution of new Medicare GME slots and make recommendations to HHS on how to distribute those slots to rural areas and in specific medical specialties.

There's also a provision in the policy outline to give hospitals ten years rather five years to establish a new per resident amount or residency full-time equivalent cap. Senators also propose removing CMS' requirement in the event of a hospital closure that it prioritize hospitals in the same region of the country as the closed hospital when redistributing slots.

"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?" Senators ask in the policy outline. "What additional policies should Congress consider to improve the distribution of unused GME slots to areas facing the greatest projected shortage of physicians?"

Meanwhile, senators repeated 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," senators say. "Instead, researchers depend on estimates of payments and the number of physicians who are trained by analyzing Medicare cost reports."

To address these issues, the senators propose to make publicly available a database on federal GME programs, including the Medicare GME, Department of Defense GME and Medicaid GME. HHS would be required to calculate Medicare GME slots per 100,000 residents by state and project physician shortages by state and assess how Medicare GME investments address these projected shortages. HHS must also reuse existing data collected for other purposes in order to minimize administrative and reporting burdens.

The Health Resources and Services Administration's most recent analysis of the health care workforce estimates there will be a shortage of 139,940 physicians across all specialties by 2036. Over that same time frame, the country would be short 68,020 primary care doctors and 42,130 psychiatrists, HRSA adds.

While Congress has added 1,200 new Medicare GME slots over the last four years, the senators say they've heard from experts this number is insufficient and GME slots need to be better targeted toward rural areas and key specialties.

Sens. John Cornyn (R-TX), Michael Bennet (D-CO), Thom Tillis (R-NC), Catherine Cortez Masto (D-NV), Marsha Blackburn (R-TN), and Robert Menendez (D-NJ) also signed onto the policy outline. -

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