Three Key GME Support Provisions in Congress's COVID-19 Emergency Relief Package

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On December 21, 2020, Congress passed a US$900 billion spending package designed to bolster the US economy and to fund programs designed to fight COVID-19 and treat patients. The President is expected to sign the bill this week. The legislation contains three important provisions supporting graduate medical education. These GME provisions provide additional funding slots to teaching hospitals, offer solutions to the so-called “resident rotator” problem, and ease rural training track requirements.

Section 126 of the House discussion draft provides for creation of an additional 1,000 funded Medicare GME positions (200 per year for five years). These additional GME slots will be distributed through an application process, and 10 percent of such positions must be reserved for rural hospitals, hospitals training residents in excess of their current Medicare GME caps, hospitals in states with new medical schools or new branch campuses of medical schools, and hospitals located in health professional shortage areas. No hospital may receive more than 25 additional Medicare-funded GME slots through this provision, and hospitals must use awarded slots to increase the number of trainees at the hospital by a number commensurate with the awarded slots. Funded positions awarded under this provision may be aggregated through Medicare affiliated group slot-sharing agreements only after a 5-year waiting period.

Section 127 of the House discussion draft makes changes to the Medicare GME rural training track (RTT) program, to provide greater flexibility for rural and urban hospitals to partner and address the physician workforce needs of rural areas. More specifically, beginning October 1, 2022, residency programs will no longer require “separate accreditation” to be eligible for RTT funding.

Section 131 of the House discussion draft provides hospitals that were adversely affected by small numbers of resident rotators with a 5-year period to re-establish new per resident amounts and GME caps. If signed by the President, this legislation will address the following three problems:

- **Accidental establishment of a hospital's resident limit, or "cap"**: The bill would permit community hospitals whose caps were accidentally established on the basis of small numbers of incidental resident rotators to build and receive Medicare funding for new residency programs. Under the legislation, any hospital whose cap was established based on training fewer than 3.0 full-time equivalent (FTE) resident rotators from new residency training programs between October 1, 1997, and the date of enactment, would be permitted to establish new GME caps under existing cap-building processes for new teaching hospitals.
- **Accidental establishment of a hospital's per-resident amount (PRA)**: The bill would permit community hospitals whose PRAs were accidentally established by small numbers of incidental resident rotators to build and receive Medicare funding for new residency training programs. Under the legislation, any hospital whose PRA was established based on training fewer than 3.0 FTE resident rotators between October 1, 1997, and the date of enactment, would be permitted to establish a new PRA under existing methodologies applicable to new teaching hospitals.
- **Extremely low base-year cap**: Any hospital whose base-year GME cap was set based on the training of less than

1.0 FTE resident prior to October 1, 1997, would be permitted to establish a new FTE cap.

Moving forward, a hospital's GME caps and PRA would not be established until the hospital trained more than 1.0 FTE resident in a given fiscal year.

The GME @ Dentons team will provide updates on related regulatory and slot application processes as they are announced. Please do not hesitate to reach out with any questions.

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