Graduate Medical Education Enhancement and the Consolidated Appropriations Act, 2021

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On December 27, 2020, the $2.3 trillion Consolidated Appropriations Act of 2021 was enacted, providing for fiscal year 2021 funding.[1] While the Act may be best remembered for $900 billion of COVID-19 relief payments, the new law included essential provisions for graduate medical education (GME). Buried within the 5593 pages are a series of incremental changes to federal funding of GME.[2] Although, the United States is facing a projected shortage of physicians, past efforts to increase GME funding have failed.[3,4] Recognizing the impending shortage of physicians, Congress created a modest expansion of federally funded training positions.[5] This article describes Sections 126, 127, and 131 of the Act and offers recommendations. Our first suggestion is to consider incorporating information from each section into a system-level strategy beginning with Section 131, then 126, and finally 127.

Consolidated Appropriations Act: Section 131

Section 131 provides relief for hospitals that have low full-time equivalent (FTE) caps or low FTE per resident amount (PRA) funding. Those hospitals may qualify for a reset of either relief through December 26, 2025.

Hospitals qualify for an FTE cap reset if they have not trained residents from new programs before the enactment date, will train residents from new programs, and meet the criteria listed in FIGURE 1. Some qualifying hospitals are likely to be those that accepted a few rotating residents from a program but may not be aware of their current cap status. We recommend that a review of cost reports or of publicly available cost report data can help determine eligibility.[6] For institutions that do qualify to reset, the challenge will be to successfully matriculate and train residents (1–3 FTE) from either a partnered or self-sponsored new program(s) by December 26, 2025. Institutions should expect the development of each new program, from program director recruitment to the first-class matriculation, to take a minimum of 2 years and likely more.

Hospitals qualify for a PRA reset if they have not entered into a Medicare GME Affiliation Agreement since the enactment date, will train residents from either new or existing programs following reset, and meet the criteria listed in FIGURE 2. Given that qualifying hospitals can train residents from either new or existing programs to reset PRA, there are fewer temporal restraints. Institutions interested in a PRA reset must withdraw or abstain from Medicare GME Affiliation Agreements, because entering into an agreement after enactment date will disqualify the hospital.

Consolidated Appropriations Act: Section 126

Section 126 provides for distribution of an additional 1000 Medicare-supported new Medicare GME resident positions, with a maximum of 200 positions to be distributed in each of the next 5 years. This provision will not fund existing resident FTE trained over a cap. Thus, programs must proportionally expand existing programs or build and fill new programs with the awarded FTE. The legislation further states that hospitals that meet the following criteria will be favored for FTE distribution:

- geographically located in a rural setting,
- currently training over FTE cap,
- located in states with new medical schools accredited as of January 1, 2000, and
- serving Health Professional Shortage Areas (HPSAs).

Another consideration will be the "demonstrated likelihood of the hospital filling the positions" within the 5 years. The hospital must increase the number of

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CATEGORY		TRAIN AT LEAST	Trained Residents from New Programs	
			If YES BEFORE ENACTMENT….	**If NO BEFORE ENACTMENT….**
A	As of date of enactment has an IME and/or DGME FTE resident cap that was established based on less than 1.0 FTE in any cost reporting period beginning ***before*** October 1, 1997.	1.0 FTE	The hospital, regardless of low FTE cap does *not* qualify for relief.	The hospital may qualify for FTE cap relief if other requirements are met.
B	As of the date of enactment has an IME and/or DGME FTE resident cap that was established based on training no more than 3.0 FTEs in any cost report period beginning ***on or after*** October 1, 1997, and before date of enactment.	3.0 FTE		

CMS proposes the accruing FTE must come from *only* "new" programs.

FIGURE 1
Full-Time Equivalent Cap Reset Criteria
Abbreviations: IME, indirect medical education; DGME, direct graduate medical education; FTE, full-time equivalent; CMS, Centers for Medicare and Medicaid Services.

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residents trained by the number of approved positions. No less than 10% of the available positions will be distributed to each group of hospitals that meet the criteria captioned above. Therefore, of the 200 positions awarded each year, 40% of those positions must be distributed to such hospitals.

The Centers for Medicare and Medicaid Services (CMS) proposes that the first application deadline will be January 31, 2022, with approved funding disbursed by July 1, 2023. Given that this section received national attention, CMS rightly anticipated intense competition, including among the teaching hospitals that meet the prioritized criteria. The proposed rules plan to limit competition in 2 ways. First, CMS proposes to reduce the award size to no more than 1.0 FTE per year to each individual hospital. Second, CMS will place the highest priority on geographic HPSA scores and specifically allocate 1.0 FTE to each hospital applicant with the highest HPSA score, then the next highest, etc, with use of prorating only if the number of hospitals with the highest score exceeds the number of residency positions available.

Use of the HPSA score will greatly reduce competition/interest in these positions from urban facilities. This mitigates concerns from the Council of Academic Family Medicine that the secondary criteria for "demonstrated likelihood of filling positions" will unintentionally place applicants in rural areas in a disadvantaged situation, as these programs are historically less likely to fill all positions.[7] While this criteria must be met, it may be accomplished through "checkbox" attestation of the Accreditation Council for Graduate Medical Education (ACGME) application submissions, initial accreditation, or attestation that the hospital is expanding an existing program. The remaining preparatory steps for the expected fall 2021 application cycle include:

- use the Health Resources and Services Administration (HRSA) HPSA Find Tool to obtain the HPSA score served by your institution/program

CATEGORY		TRAIN AT LEAST	Medicare GME Affiliation Agreements	
			If YES AFTER ENACTMENT….	**If NO AFTER ENACTMENT….**
A	As of date of enactment has a PRA that was established based on less than 1.0 FTE in any cost reporting period beginning before October 1, 1997. Typically, a Category A hospital is one that trained less than 1.0 FTE in its most recent cost reporting period ending on or before December 31, 1996, and received a very low or $0 PRA.	1.0 FTE	CMS proposes to establish a PRA in the instance where a hospital trains *less than 1.0 FTE.*	CMS proposes to establish a PRA only when a hospital trains at least 1.0 (A) or 3.0 (B), respectively.
B	As of date of enactment has a PRA that was established based on training of no more than 3.0 FTEs in any cost reporting period beginning on or after October 1, 1997, and before the date of enactment.	3.0 FTE	The MACs* will review cost reports, GME costs, FTE counts, rotation schedules, etc to determine if the requisite threshold of FTE residents are trained.	

CMS proposes the accruing FTE may come from *either* "new" or "existing" programs.

*Medicare Administrative Contractor (MAC) is a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries. Previously called a "fiscal intermediary."

FIGURE 2
Per Resident Amount Reset Criteria
Abbreviations: GME, graduate medical education; PRA, per resident amount; FTE, full-time equivalent.

or to identify potential partners, in areas with high HPSA scores, for program expansion;

- review the definitions of states with new medical schools or branches provided by CMS in their Proposed Rule document;
- obtain a copy of your most recent CMS Cost Report Worksheet Part E, Part A, and E-4;
- if classified as an urban hospital currently, determine if it is possible to reclassify as rural by January 1, 2022; and
- if currently in the process of submitting an ACGME institutional or new program application, do so by January 1, 2022.

Consolidated Appropriations Act: Section 127

The final and most generous piece of the legislation is Section 127, which aims to solve problems in prior legislation through development of a hub (urban) and spoke (rural) partnership known as a rural training track (RTT) and promote rural hospital GME funding opportunities:

- *Applicable to all specialties:* The prior "separate accreditation" requirement allowed only family medicine to capitalize on expansion opportunities. CMS proposes that on or after October 1, 2022, any program accredited by the ACGME, regardless of specialty, may qualify for adjustments to their FTE cap.
- *Rural hospital funding:* Prior legislation allowed urban hospitals to add FTE over their CAP when building an RTT. However, it did not afford rural hospitals the same adjustment. CMS now proposes that when an urban and rural hospital establish an RTT for the first time, both hospitals may receive adjustments to their FTE caps.
- *Existing program funding:* Prior legislation did not allow either urban or rural hospitals to receive FTE cap adjustments when an urban hospital added an additional rural location to an existing RTT. CMS proposes (on or after October 1, 2022) to prospectively allow cap adjustments to hospitals with existing programs and RTTs, but only when additional residents are recruited to add a new RTT "spoke" to an existing "hub."
- *3-year rolling average:* CMS also interprets this section to allow RTT FTE to be excluded in the 3-year rolling average calculations until the 5-year cap development periods are over for urban and rural facilities.

It is our opinion that qualifying for the provisions in Section 131 will be difficult and require detailed analysis. Capitalizing on this opportunity requires coordinated efforts and partnerships between urban teaching and rural hospitals that may redefine physician training in the United States. However, this funding, generated in perpetuity, is a feasible method of addressing the physician shortage through resident FTE geographic redistribution, while increasing each facility's FTE cap. Given evidence that RTT programs positively impact physician retention in rural areas, this is excellent news.[8–10] We see this section of the legislation as the most promising to expand rural medicine and address the impending physician shortage. Institutions should examine their existing infrastructure to determine what rural resources are available to take advantage of this section. Rural Health Clinics, Federally Qualified Health Centers, and Critical Access Hospitals, which now qualify with the revised rules, provide many attractive rural training sites to expand existing hub programs at rural spoke sites.

Summary

Since the inception of the Medicare caps, there has been very few opportunities to materially expand funded positions until now. The Consolidated Appropriation Act, 2021 may provide thousands of new funded US residency and fellowship training positions, with a major emphasis on rural communities. Over the next few years eligible hospitals should take advantage of Sections 126 and 131. However, we encourage organizations to challenge their GME leadership to consider potential rural partners to find ways to utilize section 127, as many limitations in RTT use have been removed. In the past, GME has functioned more as a bottleneck in terms of expanding the US physician pool—in 2021, the federal government has created paths to substantially increase physician supply and future distribution as well.

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