National Rural Health Association

October 15, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to submit a response to the Centers for Medicare and Medicaid Services (CMS) additional request for information (RFI) on residency program newness. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Background

Currently, residency programs are considered new by CMS if the residents, program director, and teaching staff are "new". CMS has interpreted this to mean the "overwhelming majority" of residents or staff are not coming from previously existing programs in the same specialty. CMS is now interested in reexamining this policy.

Historical policy decisions, namely the ability for urban hospitals to reclassify to rural for Medicare Inpatient Prospective Payment System (IPPS) payment purposes, may be contributing to the need for CMS to clarify what constitutes a "new" program. Typically, only GME-naïve or rural hospitals are able to start new residency programs and receive Medicare funding above their established caps. However, urban hospitals that reclassify to rural under 42 C.F.R. § 413.103 are eligible to receive indirect medical education (IME) funding for new programs. The intent of allowing new rural programs to receive direct GME (DGME) and indirect medical education (IME) payments was to increase rurally based physician training and grow the rural workforce. Yet workarounds by urban hospitals without clear rural affiliation have diminished this intent. The proliferation of new programs in urban reclassified hospitals has greatly increased IME spending and caused concern around how to control IME spending.

NRHA agrees that workarounds to receiving Medicare funding should be examined in cases where urban facilities have no clear affiliation with rural training. However, we urge CMS to consider the unintended consequences of establishing expanded standards for "new programs" on rural GME. NRHA is concerned that new requirements may stifle the growth of new training opportunities in rural areas. Generally, **we ask that CMS does not move forward with new program criteria or otherwise exempt rurally located hospitals** designated as such under § 1886(d)(2)(D) of the Social Security Act (SSA), critical access hospitals, and rural emergency hospitals. In the event that CMS initiates future rulemaking on new residency programs, NRHA advocates for the solutions below.

RuralHealth.US
50 F. St., N.W., Suite 520
Washington, DC 20001 | 202-639-0550

Newness of Residents

In FY 2025 IPPS proposed rule, CMS put forth a 90% threshold for determining the newness of residents. Under this proposal, 90% of individual full time equivalent (FTE) residents must not have previous training in the same specialty as the new program. CMS recognized that there may be certain challenges unique to small or rural programs when developing new residency programs that could make meeting the proposed 90% threshold difficult. Accordingly, CMS solicited comments on whether a "small program" should be defined as 16 residents or less and how small programs should be required to meet any thresholds, if at all.

First, NRHA believes that CMS should defer to accrediting bodies' expertise when determining newness. Implementing new, more stringent standards will be duplicative of regulations by ACGME and other accrediting organizations. However, given CMS' clear interest in delineating updated standards for new programs, **NRHA agrees that small programs should be defined in order to be exempted from any future new resident thresholds or to allow for more flexible criteria.**

NRHA agrees with CMS's proposal for small programs to be defined as those with 16 residents or fewer. This number aligns with the minimum number of residents required by ACGME for most specialties. We urge CMS to refine the application of small programs to those that spend more than half of the time training in a geographically rural location.[1] Some specialties, such as plastic surgery, have small programs but train in urban settings that are not challenged by the same recruitment or resource constraints as small, rural programs.

CMS should use the definition of a small, rural program to exempt these programs from any threshold. Small, rural programs have unique challenges associated with starting a new residency program. New rural programs often matriculate residents from various sources, including transfers from other programs in the same specialty. For example, rural track programs (RTPs) will take second- or third-year residents to ensure there are more senior residents to jumpstart the program. For a small program 3-year program with a resident in each year, two upper-level transfers would mean only 33% of residents are "new." Even a program with 6 residents, one of which transferred from another program, would be disqualified from being considered "new." If CMS defines a small program, it should be for the purposes of exempting such program from the "new program" definitions.

If CMS moves forward with a threshold for determining resident newness, NRHA advocates for applying the threshold only to the PGY-1 year of training. As mentioned above, new rural programs often need to recruit PGY-2 or PGY-3 residents to join the program as "experienced" residents. Thus, CMS should only require that 90%, or any other threshold, of PGY-1 residents are new. In addition, CMS should adjust the threshold to be lower for small, rural programs. For example, small, rural programs should meet a 25% new resident threshold for the PGY-1 year only.

Newness of faculty

Again, NRHA believes that CMS should defer to accrediting bodies' expertise when determining newness. ACGME already sufficiently regulates the issue of experienced teaching staff in a residency program. However, we understand the agency's interest in further defining new programs and put forth the following alternative policies.

---

[1] Geographically rural according to 1886(d)(2)(D) of the SSA and excluding rural reclassified hospitals under 1886(d)(8)(E) and 42 C.F.R. § 413.103.

RuralHealth.US
50 F. St., N.W., Suite 520
Washington, DC 20001 | 202-639-0550

National Rural Health Association

CMS must exempt small, rural programs that primarily train in geographic areas for any new faculty or program director (PD) standards. NRHA also advocates for the definition of a small, rural program defined above, as 16 residents or less, in the determination of faculty and program director newness. Most rural programs, even if they are not considered “small,” face faculty recruitment challenges. New small and rural programs often recruit from other programs to ensure that their faculty have the requisite experience to precept.

For PDs specifically, CMS must align with ACGME standard accreditation requirements. ACGME guidelines require that all specialties have some combination of three years of educational and/or administrative experience before an individual becomes a PD. Further, the limited pool of physicians that are qualified to serve as a PD is even smaller than that of faculty. Experienced PDs are the strongest and most desirable candidates. For small, rural programs, like rural track programs, the best person for the role is typically the existing urban PD while the local rural site director learns the role under their guidance. The site director then assumes the position of the PD. This practice is within ACGME expectation of new PDs having three years of experience in administration.

Alternatively, CMS could implement a “safe harbor” provision. This would allow new programs to operate separately but concurrently with other programs that link previously to the program director, faculty, and residents. A program would be considered “new” when it receives accreditation, even if the PD, faculty, and/or residents previously worked or trained at another program as long as the other programs continue to operate as existing programs for the first year of the new program. If the new program and existing program operate simultaneously, it is clear that the existing program could not be a relocation of the other program because they both operated concurrently for a year. This would be an administratively simple solution to determining whether a program is new, rather than relocated, while also deferring to accrediting bodies’ judgment.

NRHA thanks CMS for the opportunity to weigh in on the issue of residency program newness. We look forward to our continued work together on behalf of rural communities. If you have any questions or would like to discuss our response further, please contact NRHA’s Government Affairs and Policy Director, Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association