National Rural Health Association

June 24, 2024

Chairman Ron Wyden
U.S. Senate Committee on Finance
221 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Michael Bennet
Senator
261 Russell Senate Office Building
Washington, D.C. 20510

The Honorable John Cornyn
Senator
517 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Thom Tillis
Senator
113 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Robert Menendez
Senator
528 Hart Office Building
Washington, D.C. 20510

The Honorable Catherine Cortez Masto
Senator
520 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy
Senator
455 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Marsha Blackburn
Senator
357 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Wyden and Members of the Bipartisan Medicare GME Working Group,

The National Rural Health Association (NRHA) appreciates the opportunity to provide feedback on the Bipartisan Medicare GME Working Group (Working Group's) draft Medicare Graduate Medical Education (GME) proposal. Expanding rural physician training opportunities through Medicare GME is one critical avenue for alleviating the rural healthcare workforce shortages across the country.

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, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

In 2017, the Government Accountability Office (GAO) predicted that rural areas would see a deficit of over 20,000 primary care physicians by 2025.[1] While meaningful changes in GME policy have been made in recent years[2] rural communities need further federal investment to close disparities in healthcare access. Only about 2% of Medicare supported GME residency training occurs in rural areas[3] despite the overwhelming need for physicians and evidence showing that rural training is the

[1] Government Accountability Office, *Physician Workforce: Locations and Types of Graduate Training Were Largely Unchanged, and Federal Efforts May Not Be Sufficient to Meet Needs*, 12 (2017), https://www.gao.gov/assets/gao-17-411.pdf
[2] *See generally* 42 U.S.C. § 1395ww(h) (2022).
[3] Jacob Rains, et al., *The Distribution of Additional Residency Slots to Rural and Underserved Areas*, 330 JAMA 968, 968 (2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10413210/; Government Accountability Office, *Graduate Medical Education: Programs and Residents Increased during Transition to Single Accreditor; Distribution Largely Unchanged*, 24 (2021), https://www.gao.gov/assets/gao-21-329.pdf.

best predictor of physicians choosing to practice in a rural area.[4] Roughly 70% of all primary care health professional shortage areas (HPSAs) and 68% of all mental health HPSAs are in rural areas.[5] Research indicates that residents in a primary care specialty that spend 50% or more of their training time in a rural location are substantially more likely to choose to practice in a rural area.[6] As such, NRHA is pleased to see the Working Group's attention to the need for improvements in rural GME to help shape a future where access to a physician does not depend upon where one lives.

**Summary of Recommendations:**

- Create at least 14,000 new GME slots with a set aside for geographically rural hospitals.
- Distribute at least half of all new slots to primary care residencies and the remainder to high-need specialties in rural areas, including OBGYN, psychiatry, and general surgery.
- Define "rural hospital" to include:
    - Hospitals located in a rural area under § 1886(d)(2)(D), excluding reclassified hospitals under (d)(8)(E);
    - Hospitals with a Rural-Urban Commuting Area code of 4 or higher;
    - Sole community hospitals; and
    - Sites within 10 miles of a sole community hospital.
- Invest further in the Rural Residency Planning and Development Program and authorize the program to incentivize rural hospitals to train physicians.
- Address challenges for rural hospitals with low GME caps:
    - Remove the Section 131 cap reset deadline of December 31, 2025, and instead allow rural hospitals with low caps to reset at any time.
    - Extend the cap building period for resetting rural hospitals and GME-naïve rural hospitals to 10 years.
    - Remove caps for programs with 16 residents or less.

**Section 2. Additional and Improved Distribution of Medicare GME Slots to Rural Areas and Key Specialties in Shortage.**

The maldistribution of physician training, exacerbated by the first two rounds of Section 126 slot distributions, is a key concern of NRHA members. NRHA thanks the working group for recognizing the need for targeted GME funding to rural areas, particularly its proposed revision to the formula enacted in the CAA, 2023. NRHA supports the new rural hospital definition as it will guarantee that new slots are distributed to geographically rural training sites.

- *How many additional Medicare GME slots are needed to address the projected shortage of physicians?*

**NRHA suggests that Congress create at least another 14,000 additional slots.** Since 2020, Congress has created an additional 1,200 GME slots. These have been crucial for expanding training and providing funding for hospitals training over their Medicare caps. However, one slot is equivalent to training one resident physician for one year. Effectively, these 1,200 slots will yield 400 physicians assuming an average resident is in a 3-year residency program. When distribution is complete, this

[4] Deborah J. Russell, et al., *Family Medicine Residencies: How Rural Training Exposure in GME Is Associated With Subsequent Rural Practice*, 14 J. GRADUATE MED. ED. 441, 444 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9380633/pdf/i1949-8357-14-4-441.pdf.
[5] https://data.hrsa.gov/default/generatehpsaquarterlyreport.
[6] Russell, *supra* note 4, 444-45.

number will realistically be lower because slots have gone to specialties with longer residencies, like general surgery. While hundreds of newly trained physicians are a welcome addition to the healthcare workforce, the reality is that many more are needed.

NRHA supports the proposal to limit the number of new Medicare GME slots that a hospital can receive to 10. This limit gives the opportunity to train approximately 3 additional residents in a 3-year program.

- *To address the disproportionate shortage of primary care doctors and psychiatrists, what percentage of new Medicare GME slots should be dedicated toward these two specialties? What additional Medicare GME policies should Congress consider to encourage more residents to enter these specialties?*

The Health Resources and Services Administration (HRSA) predicts a shortage of almost 70,000 primary care physicians and 140,000 physicians across all specialties by 2036.[7] Rural areas will see a 56% shortage of physicians.[8] Specifically, rural areas are expected to face a shortage of over 6,000 family medicine physicians and about 7,000 internal medicine physicians.[9] HRSA further predicts that by 2036 the supply of rural psychiatrists will be down an additional 25% from 2021 meaning that 20% of total rural needs will be met.[10] With these projections in mind, NRHA agrees that targeting new slots to primary care and psychiatry specialties is necessary. **In addition, NRHA suggests that slots also be targeted to rural OBGYN programs** and OBGYN fellowships after a family medicine residency**.** The U.S. is facing a maternal health crisis with the impacts being more acute for women of color and rural women. According to HRSA, OBGYNs practicing in rural areas will be down 16% from 2021 to 2036 and only 54% of need will be met.[11]
su
NRHA strongly recommends that new GME slots should only be created and distributed to primary care or specialties that are in high need in rural areas. As such, **at least half of all new slots should go to primary care**, which should include family medicine, internal medicine, and pediatrics. **The remainder of slots should be reserved for high-need specialties in rural areas, which should include psychiatry, obstetrics, and general surgery.**[12]

- *Would the proposed changes to the definition of rural hospitals in the CAA, 2023 GME allocation formula outlined above improve the distribution of slots to rural communities?*

**NRHA strongly supports the proposed definition of rural. The proposed change to the definition of rural hospitals outlined above would improve the distribution of slots to rural communities and address inequities in current allocation methods.** As the Working Group is likely aware, Section 126 mandated that 10% of slots go to rural hospitals to perform rural training; however, this has not been achieved as congressionally intended. One of several reasons why is because the statute allows "hospitals […] treated as being located in a rural area," or urban hospitals reclassified to rural, to count towards this rural set aside. **In the first round of awards, only one rural referral center (RRC) that is geographically rural received slots** and one RRC would use

[7] https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand
[8] *Id.*
[9] https://data.hrsa.gov/topics/health-workforce/workforce-projections
[10] *Id.*
[11] *Id.*
[12] We are using HRSA's shortage projections and eligible specialties in the Rural Residency Planning and Development program to inform our choices for high-need specialties.

slots to train residents for greater than 50% of the time in a nonmetropolitan area. Overall, the slots the vast majority of slots allocated for rural hospitals went to residency programs located in urban HPSAs.[13] **In the second distribution round, two geographically rural hospitals and one urban hospital training residents in a rural area for greater than 50% of the time received slots.** The remaining went to urban hospitals. NRHA does not believe this is consistent with congressional intent and asks that the Working Group remedy the issue in future legislation.

At the outset, the ability to reclassify was meant to aid rural hospitals that were grouped into a larger urban area or hospitals that treat a large share of rural patients. However, from 2014 to 2022, the number of RRCs increased from 333 to 781.[14] One reason for this growth is the decision of the court in *Geisinger Community Medical Center v. U.S. Department of Health and Human Services (HHS)* in 2015, which held that hospitals could both convert from urban to rural for IPPS payment and simultaneously convert back to urban for wage index purposes.[15] RRCs are classified as rural under 42 C.F.R. § 412.103. In 2014 the majority (213) of RRCs were rurally located.[16] As of 2022 there were 208 rural RRCs and 573 urban RRCs.[17] Overall RRC growth exploded in that eight-year period and the growth of urban RRCs substantially outpaced that of rural RRCs; in fact, rural RRCs actually declined.[18] The increase in RRCs suggests that urban hospitals receive benefits from the designation, from clinical payments to GME reimbursement, intended for those truly practicing and training in rural areas.

- *Is it necessary to provide further clarification in the existing statute to ensure that CMS allocates GME slots to particular categories as specified in the CAA, 2023 GME allocation formula?*

Clarification on the distribution of additional GME slots currently allocated, or those allocated in the future, will be paramount. While the number of slots created is key to addressing shortages, NRHA believes that where the slots go is even more important. **NRHA recommends that Congress be more prescriptive in where slots are targeted.** For example, CMS' choice to prioritize applications for Sec. 126 and the upcoming Sec. 4122 slots based on the hospital's HPSA score has led to mostly hospitals in urban HPSAs receiving slots.[19] Congress must clearly legislate how applications should be prioritized in order to ensure that new residency positions are funded in rural and underserved areas that need primary care physicians or high-need specialties.

Further, **any legislative mandate on prioritization or targeting slots should not rely upon HPSA scores alone.** Currently, three primary factors are used in scoring criteria for all HPSA disciplines (primary care, mental health, and dental): (1) population-to-provider ratio; (2) poverty rates; and (3) travel distance or time to the nearest accessible source of care. The measures do not fully reflect rurality or rural relevant population health measures and ultimately can disadvantage rural areas. In the past, NRHA has advocated for including Rural-Urban Commuting Area (RUCA) codes, Frontier and

[13] Rains, et al., *supra* note 3.
[14] Randall Longenecker & Lori Rodefeld, *Rural track program funding: An erosion in definitions of rural places requires new action*, NATIONAL RURAL HEALTH ASSOCIATION, 2 (2022), https://www.ruralhealth.us/getmedia/f71ebd3b-543e-424e-8b7e-885d7c9d2a2f/NRHA-Policy-Paper-final-Rural-Reclassified-Hospitals-and-RTPs_1.pdf.
[15] *Geisinger Cmty. Med. Ctr. v. Sec'y. U.S. Dept. of Health & Human Services*, 794 F.3d 383 (3d Cir. 2015); 42 C.F.R. § 412.230(a) (2023).
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] Rains et al., *supra* note 3.

Remote (FAR) codes, and certain measurements of population health status and health disparities within, and in addition to, criteria associated with HPSA scoring.[20]

Along those lines, NRHA recommends that Congress use measures of rurality and health disparities to target slot allocations. Outside of HPSAs, there are few if any federal measures of workforce need that can easily be incorporated into legislation or regulations. However, given that HPSA scores and designations may not accurately capture rural need, Congress must consider linking GME funding to population health needs in addition to provider shortages.[21] These could include life expectancy from birth, median age of populations, disability rates, and mortality rates from all causes of death.

**Last, NRHA urges Congress to remove the pro rata application provision from future slot distributions.** The proposed policy "would maintain other aspects of the GME allocation formula enacted in the CAA, 2023." The CAA, 2023 contained a provision to ensure that all qualifying hospitals that apply for new slots receive at least a fraction of 1 slot before any hospital receives more than 1 slot.[22] We are concerned that another pro rata approach to distribution would discourage rural hospitals from applying for slots because they may not receive a full slot, or a full FTE, due to how slot equivalency is calculated. One slot covers the cost of training one resident for one year; thus, a fraction of an FTE is likely not incentive enough for rural programs to apply because the majority of costs associated with the resident training would not be funded by Medicare. Rural hospitals are less able to shoulder unfunded training compared to urban academic medical centers. For more information, please refer to NRHA's fiscal year 2025 Inpatient Prospective Payment System (IPPS) comment.[23]

- *How should Congress approach the role of hospitals which engage in "rural reclassification," wherein a hospital changes its designation from urban to rural, then back to urban within one calendar year for the purposes of receiving Medicare GME payment?*

We caution Congress against excluding all reclassified hospitals in any future legislative efforts but instead limit the allowance of reclassified hospitals to be those geographically located in a rural area as defined by RUCA codes 4 – 10. Reclassification is a needed tool for certain rural hospitals that are in a rural census tract of a Metropolitan Statistical Area (MSA). These hospitals are in communities that are effectively rural but are grouped in with a larger urban area and legitimately need the reimbursement benefits that a rural classification offers. These facilities frequently complete a significant amount of rural training as compared to reclassified facilities located in purely urban communities. Rural hospitals in this position should not be shut out of opportunities to grow their residency programs given their important role.

- *How could Congress improve the recruitment of physicians to work in rural or underserved communities?*

Support for undergraduate medical education (UME) is another way to encourage physicians to work in rural or underserved communities. Medical students' decisions on where to ultimately practice are

[20] https://www.ruralhealth.us/getmedia/1216620f-8489-4531-9b3c-e15584155868/2020-NRHA-HPSA-comments.pdf
[21] Council on Graduate Medical Education, *Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities* (Apr. 2022), 11, https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/reports/cogme-april-2022-report.pdf.
[22] 42 U.S.C. § 1395ww(h)(10)(B)(iii) (2024).
[23] https://www.ruralhealth.us/getmedia/fdb027e0-cd6e-42a6-8874-a965c1f8084e/NRHA-FY25-IPPS-comment-6-10-2024.pdf.

influenced by where they rotate and train. Exposing medical students to rural and community-based settings can help recruit and retain a rural physician workforce. Although outside of the Finance Committee's jurisdiction, legislation such as S. 3968/H.R. 7258, the Community TEAMS Act could encourage more rural rotations during medical school through funding to expand medical student rotations in rural community-based settings like rural health clinics.[24]

In addition, NRHA recommends that Congress improve physician recruitment in rural and underserved areas by requiring programs to accept applications from DOs and the osteopathic licensing exam, the COMLEX-USA, if an examination score is required, as described in H.R. 751, the Fair Access in Residency Act (FAIR).[25]

The osteopathic medical education emphasis on treating rural and underserved communities leads a large share of osteopathic graduates to primary care. In 2024, 52.1% of matched U.S. Doctor of Osteopathy (DO) seniors went into primary care, compared to only 35.6% of U.S. Doctor of Medicine (MD) seniors.[26] This translates directly to the physician workforce for these communities as DOs tend to fill the primary care needs of rural communities at a rate 2.3 to 2.5 times higher than their allopathic colleagues.[27]

However, DOs currently face exclusion and undue burdens when applying for Medicare-funded residency programs. According to National Resident Matching Program data, 32% of residency program directors never (7%) or seldom (25%) interview DO candidates.[28] More than half (56%) of GME programs that consider DOs mandate that they take the MD licensing exam, the United States Medical Licensing Examination (USMLE). However, DO students take the COMLEX-USA for graduation and licensure. DO and MD requirements are parallel, with both medical exams leading to unrestricted physician licenses in all 50 states.

Federally-funded Medicare GME programs should not be allowed to discriminate against a class of physicians based solely on degree and exam type. These restrictive practices frustrate DO delivery of healthcare services and pose a significant threat to achieving high-quality, affordable patient-centered care. Moreover, these practices exacerbate the workforce shortage by forcing DOs to pursue residency programs outside their preferred locations (typically, rural and underserved areas). Because 73% of DOs will practice in the state where they complete residency training, Medicare GME programs that refuse to consider DO applicants or who require the USMLE adversely impact the physician workforce in rural and underserved communities.

- *Would increasing the cap for hospitals in states with the lowest number of GME slots, rather than for all hospitals, improve distribution of GME slots to areas with workforce shortages?*

Increasing the cap for hospitals in states with the lowest number of GME slots may help alleviate some workforce shortages. However, in some cases, the raw number of GME slots in a state may not be the perfect measurement. Congress should consider looking at slots per capita to determine where

[24] Community Training, Education, And Access for Medical Students Act, H.R. 7258, S. 3968, 118th Cong. (2024), https://www.congress.gov/bill/118th-congress/senate-bill/3968/text.
[25] Fair Access in Residency Act, H.R. 751, 118th Cong. (2024), https://www.congress.gov/bill/118th-congress/house-bill/751.
[26] https://www.nrmp.org/wp-content/uploads/2024/03/Advance-Data-Tables-2024.pdf.
[27] *Id.*
[28] https://www.nrmp.org/wp-content/uploads/2022/09/PD-Survey-Report-2022_FINALrev.pdf.

a cap increase may be the most effective. For example, small states like Massachusetts with large academic medical centers, likely have a disproportionate share of Medicare funded slots. Other states may have few slots but a small population, or few slots and a larger population.

**Section 3: Encouraging Hospitals to Train Physicians in Rural Areas**

- *What barriers exist for hospitals in rural and underserved areas to launch new residency programs supported by Medicare GME?*

145 rural hospitals have been identified as good candidates for starting a new residency program.[29] Developing a new GME program typically takes 2 to 4 years and is significantly resource intensive. Hospitals must identify or become an ACGME sponsoring institution, conduct community and stakeholder engagement, earn accreditation, build the curriculum, and recruit a program director, faculty, and residents. This process requires significant upfront investment, both financially and in terms of time and personnel, both of which are barriers for rural hospitals.

**Robust investment in the Rural Residency Planning and Development Program (RRPD) along with authorizing the program,[30] are important steps to encourage rural hospitals to take up physician training.** NRHA underscore the importance and meaningful outcomes of RRPD to date as a pilot program. Rural hospitals often lack the resources to start up and maintain rural residency training programs. Since 2019, RRPD, housed in Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA), has provided qualifying rural sites with $750,000 over a 3-year period to help develop a new rural residency training program. RRPD has shown proven results since its inception.[31] As of April 2024, RRPD grantees have created 44 new accredited rural residency programs or rural track programs (RTPs), received approval for 563 new residency positions in rural areas, and enrolled 306 resident physicians in rural clinical settings.[32] These programs are in highly needed specialties such as family medicine, internal medicine, psychiatry, and general surgery.[33] Additionally, an analysis of training settings shows that rural referral centers (RRCs) and Sole Community Hospitals (SCHs) were the most common sites followed by system-affiliated primary care clinics.[34] Other safety net providers, like Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs) serve as RRPD training sites as well.[35]

General GME payment reform for rural hospitals is also needed to incentivize rural training. As in S. 230/H.R. 8324, the Rural Physician Workforce Production Act, a rural per resident payment would more accurately capture the costs of training residents in rural sites and adequately reimburse rural hospitals. S. 230 outlines a rural per resident payment equal to the median national direct GME

[29] Mukesh Adhikari, et al., *Characteristics of Hospitals by Graduate Medical Education Expense Category: Implications for Rural Residency Program Expansion*, 99 ACAD. MED. 567 (2024), https://pubmed.ncbi.nlm.nih.gov/38060405/.
[30] Rural Residency Planning and Development Act, H.R. 7855, 118th Cong. (2023) https://www.congress.gov/bill/118th-congress/house-bill/7855.
[31] Erin Fraher, et al., *Bolstering the rural physician workforce in underserved communities: Are Rural Residency Planning and Development Programs finding the sweet spot?* 39 J. RURAL HEALTH 521, 522, 526 (2022), https://pubmed.ncbi.nlm.nih.gov/36566476/.
[32] https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd
[33] *Id.*
[34] Fraher, *supra* note 31, at 524.
[35] *Id.*

training costs per FTE for 2015.[36] NRHA suggests one change to S. 230, which is to match the definition of a rural training location in section (a) to the definition of rural hospital proposed in this outline.

Another option would be to create a rural payment equal to the national median of all IME and direct GME payments. This would be a national per resident payment that is not a hospital specific rate, unadjusted by Medicare volume, and would apply to all hospitals, including SCHs and MDHs that are currently disadvantaged in GME payments (as described further below).

Further, if CAHs directly incur the costs of training residents they currently receive 101% of reasonable costs and do not receive IME, which NRHA members have noted is often not sufficient to support a residency program. NRHA recommends that CAHs be eligible for any new rural GME funding mechanism to help encourage CAHs to be sponsoring institutions for residency programs.

- *What revisions to IME payment are needed in order to improve financial support for rural hospitals interested in establishing residency training programs, or otherwise improve the Medicare GME program to support rural hospitals?*

**NRHA agrees that SCHs and MDHs must be paid equitably for rural training.** SCHs and MDHs are paid at the greater of the federal rate (IPPS rate) or a hospital-specific rate. Those paid under the hospital-specific rate do not currently receive indirect medical education (IME) payments. SCHs and MDHs represent almost 80% of rural hospitals eligible to establish training programs but are disincentivized under the current GME payment framework.[37] Equitable IME payments will help SCHs and MDHs currently training residents and those that are interested in starting a residency program.

NRHA asks that Congress amend § 1886(b)(3) to rebase and create a future fiscal year for SCHs and MDHs that develop or expand a residency program in a year after their hospital-specific rate was calculated.[38] This would require removing estimates of IME, if any, from the hospital's base year and making the hospital eligible for IME payment adjustments in the same manner as other subsection (d) hospitals. This would ensure that the hospitals do not receive duplicate payments. At the same time, there must be explicit statutory language providing that these rural hospitals receive the full IME payment adjustment as hospitals paid under the federal rate.

- *What programs under the jurisdiction of the Senate Finance Committee can provide targeted outreach and technical assistance to rural hospitals so they can apply for Medicare GME slots?*

NRHA recommends the Working Group authorize the RRPD program (as described in Section 3) given its considerable success in building residency training capacity in rural areas. Given close ties to the GME program, the RRPD authority could fall under the jurisdiction of the Finance Committee within the Social Security Act. This model is similar to the authorities for the Federal Office of Rural Health Policy and Medicare Rural Hospital Flexibility (Flex) program. The Flex program authority could be an additional vehicle to provide resources towards technical assistance and outreach regarding rural

[36] Rural Physician Workforce Production Act, S. 230, 118th Cong. § (a) (2023), https://www.congress.gov/bill/118th-congress/senate-bill/230.
[37] Alliance for Rural Hospital Access, *SCHs, MDHs Can Improve Rural Physician Shortages*, https://ruralhospitalaccess.org/wp-content/uploads/2023/05/PositionPaper_118thCongressTrainingPrograms_Sept2023Update.pdf.
[38] *Id.*

hospital residency training. In addition, Congress should mandate that CMS provide technical assistance (TA) to rural hospitals that are interested in applying for new slot opportunities or starting a new residency program. CMS is well positioned to help rural hospitals navigate the complexities of Medicare-funded GME, in addition to capacity development support from the Federal Office of Rural Health Policy.

- *Should guardrails be put in place to ensure patient outcomes and a resident's educational experience are not negatively impacted by an extension of flexibilities that allow teaching physicians to use telehealth to train resident physicians?*

Telehealth offers promising solutions. The pandemic's emphasis on telehealth has paved the way for its use in residency training. The extension of virtual supervision of residents for telehealth services is critical for rural residency programs allowing for safe and effective patient care. The Accreditation Council for Graduate Medical Education (ACGME) has also allowed programs to use telehealth visits in residency training, which broadens the rural patients served by the program. Residency programs have also been able to utilize preceptors from outside their region further supporting faculty recruitment in high need specialties.

- *How can existing rural track programs be strengthened and expanded through Medicare GME?*

RTPs are eligible for Medicare GME funding if greater than 50% of training occurs in non-metropolitan counties. In many cases, metropolitan vs. non-metropolitan counties is not the most granular nor effective definition to use when targeting resources to rural areas. In the case of RTPs, there are only 150 ACGME-accredited programs with greater than 50% training in non-metropolitan counties. However, if the Federal Office of Rural Health Policy definition of rural[39] was used instead, an additional 203 ACGME-accredited programs would qualify for GME funding, bring the total programs focused on rural training closer to 350. This would further strengthen the RTPs, including those set up through the RRPD program, and align with the Working Group's intent to encourage hospitals to train physicians in rural areas.

In the past, the only way for capped urban hospitals to increase their caps was to sponsor an RTP. As urban RRCs have proliferated, and thus more urban hospitals have become eligible for more IME, RTPs have become a less attractive option for increasing caps. Due to misaligned incentives, there may be fewer new RTPs started. NRHA suggests that Congress monitor this situation and consider how urban reclassified hospitals' eligibility for increased IME caps may inadvertently stifle the growth of RTPs.

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

- *Should Congress include additional specifications for a GME Policy Council in order to improve its success in allocating GME slots to physician specialties projected to be in shortage?*
- *Does the existing Council on Graduate Medical Education (COGME), a federal advisory committee that assesses physician workforce trends, fulfill the goals of this new Medicare GME Policy Council? How can Congress enhance the work of the COGME?*

[39] FORHP rural includes (1) all nonmetropolitan counties, (2) all outlying metropolitan counties without an urbanized area (50,000 people or more), (3) all metropolitan census tracks with Rural Urban Commuting Area codes 4 – 10, and (4) metropolitan census tracts of at least 400 square miles in area with population density of 35 or less per square mile with RUCA codes 2-3.

**A new GME Policy Council's statutory mandate and authority should differ from that of COGME in order to avoid creating another redundant advisory group.** COGME's statutory duties include making recommendations to the Secretary of HHS, the Senate Health, Education, Labor, and Pensions Committee, and House Energy and Commerce Committee.[40] Recommendations by a GME Policy Council must be made on the supply and distribution of physicians, current and future shortages, policies around GME and UME financing, and related matters.[41]

**The HHS Office of the Secretary should house the GME Policy Council and be required to take its findings and recommendations directly into account for rulemaking around GME.** The Council should use HRSA's Bureau of Health Workforce shortage projections to inform its recommendations and ensure that slots are distributed to the specialties and locations that are most in need.

**Section 5:**

- *How much time do hospitals with low GME caps need to reset their caps? Should additional hospitals be eligible to reset their low GME caps? What should be the eligibility criteria of these additional hospitals?*

NRHA supports Congress' work in the CAA, 2021 on Section 131 to allow certain hospitals to reset their low per resident amounts (PRA) and low GME caps. However, the deadline to do so is December 31, 2025, meaning that realistically, hospitals needed to be aware of this opportunity in January 2021 and immediately start work towards adding new residency positions and recruiting residents at that time. For a rural hospital, the time between the passage of the CAA, 2021 and the end of 2025 may not be long enough especially for hospitals that accidentally triggered a low GME cap or per resident amount.[42] Further, rural hospitals may have inadvertently established a low cap and PRA by allowing residents to rotate at the hospital and not claiming them on the cost report or paying the training costs.[43] **NRHA recommends that rural hospitals with low caps should qualify for a PRA or GME cap reset at any time and Congress should remove the upcoming deadline for rural hospitals.** Further, **the cap building period for any GME-naïve rural hospital should be longer than 5 years.** We agree with the Working Group that 10 years is a sufficient cap building period.

Congress must also consider removing GME caps for small rural hospitals. In the fiscal year 2025 IPPS proposed rule CMS proposed that a small program be defined as 16 residents or less.[44] **NRHA urges Congress to exempt all rural hospitals training 16 or fewer residents from GME caps**, using the proposed definition of rural above. This would allow established programs with less than 16 residents to expand within their capacity. Removing caps for programs training 16 or less residents would fund four residents per year for four years (i.e., covering almost any specialty necessary in a rural setting).

---

[40] 42 U.S.C. § 294o(a)(1) (2022).
[41] *Id.*
[42] Emily Hawes, et al., *Rural Residency Training as a Strategy to Address Rural Health Disparities: Barriers to Expansion and Possible Solutions*, 13 J. GRADUATE MED. EDUC. 461, 462 (2021), https://meridian.allenpress.com/jgme/article/13/4/461/469314/Rural-Residency-Training-as-a-Strategy-to-Address.
[43] *Id.*
[44] 89 Fed. Reg. 36,222.

**Section 6**

- *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?*

Yes, the proposed change would help redistribute slots to rural and underserved areas. NRHA supports S. 703, the Physicians for Underserved Areas Act, and advocates for its inclusion in a final legislative package.[45] Under current law, if a hospital with an approved medical residency program closes, the CMS must redistribute the hospital's residency positions to other hospitals in the following order: (1) hospitals in the same core-based statistical area as the closed hospital, (2) hospitals in the same state as the closed hospital, (3) hospitals in the same region of the country as the closed hospital, and (4) other remaining hospitals. In order to receive the additional positions, hospitals must demonstrate a likelihood of filling the positions within three years. S. 703 removes the requirement that the CMS prioritize hospitals in the same region of the country as the closed hospital. It also requires hospitals to demonstrate a likelihood of (1) starting to use the positions within two years, and (2) filling the positions within five years.[46]

**Section 7**

- *What additional information should teaching hospitals report, in addition to what is proposed above, in order to improve accountability of federal GME investments?*

NRHA agrees that there should be more accountability around the GME program, which is often described as a "black box." We highlight the need to balance transparency and accountability with the administrative burden on under-resourced rural hospitals. If a rural hospital is not a sponsoring institution for a residency program, meaning that it only hosts rotating residents, it should not be responsible for reporting requirements. The sponsoring institution of the resident should be responsible for all reporting. This would further enable more rural facilities to host resident rotations.

**NRHA recommends that Congress also require teaching hospitals to report the number of residency applications each of their programs receive by degree type (DO or MD) and the number of accepted residents to each program by degree type.** These reports should include an affirmation DO applications and the COMLEX-USA are equally accepted for consideration, as described in the FAIR Act.[47]

DOs are too often excluded or face undue burdens when applying for Medicare-funded residency programs. A recent AACOM survey of students found that 62% of osteopathic medical students experienced bias during the match process due to their degree, and that 36 percent of them did not rank a specialty or a program in the match because it did not accept or have DOs.

Medical school is demanding, and osteopathic medical students should not be subjected to the additional 32 hours and $2,335 in exam fees, as well as prep costs and time, that are required to take the USMLE, an exam that is not designed for the osteopathic profession or needed for licensure or practice. Research has shown that student performance on the COMLEX-USA is predictive of their

[45] Physicians for Underserved Areas Act, S. 703, 118th Cong. § 2 (2023) https://www.congress.gov/bill/118th-congress/senate-bill/703.
[46] *Id.*
[47] H.R. 751 (2023).

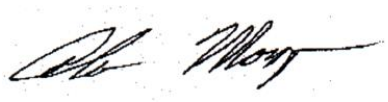
USMLE performance. Furthermore, the American Medical Association promotes equality in GME for DOs and MDs, including equal acceptance of the COMLEX-USA and USMLE at all U.S. residency programs.

> Almost, one third of residency program directors report that they never or seldom interview DO candidates and more than half of GME programs that consider DOs mandate that they take the USMLE. This has resulted in more DOs taking this unnecessary exam and applying to more residency programs than their MD counterparts in order to remain competitive. Since 2016, the number of DOs taking both the USMLE and the COMLEX has increased by 37 percent. In 2023, osteopathic medical students applied to 20 more residency programs on average (92.9) than their US MD colleagues (72.9).

By requiring programs to report on resident applications and acceptance, DOs and MDs will be better equipped with the knowledge to pursue their preferred specialties and training locations. Increasing access and improving transparency in the Medicare GME reporting system will benefit system, the residents who train in it, and the patients that they serve.

NRHA thanks the Working Group for their efforts on improving GME and for the opportunity to submit public comments. We look forward to working with the Senators on this legislation. For any additional information, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us).

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association