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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mailstop C-4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Program Newness Request for Information

Dear Administrator Brooks-LaSure:

The AAMC (Association of American Medical Colleges) welcomes the opportunity to comment on policies affecting new residency programs through a request for information (RFI) issued in the fiscal year (FY) 2025 Inpatient Prospective Payment System (IPPS) 89 *Fed. Reg.* 68986 regarding "Program Newness Request for Information" issued by the Centers for Medicare & Medicaid Services (CMS or the Agency).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

When residents from a new residency program train at a non-teaching, rural, or rural-designated hospital, the facility may expand its GME cap proportional to the duration of resident training at the hospital. Since the release of the FY 2025 IPPS proposed rule, our member institutions have raised significant questions regarding CMS's intentions in changes to the criteria for determining

whether a program qualifies as new. Among their primary concerns are the substantial financial investments required to establish new residency programs, coupled with the uncertainty surrounding potential policy shifts that could affect the future of graduate medical education (GME) reimbursements.

Institutions bear the high costs of developing residency programs without any assurance that CMS will classify them as "truly new." This uncertainty should not be compounded by punitive or overly burdensome policies. The AAMC reiterates our previous comments, emphasizing the need for any revisions to the newness determination policy to be clear, objective, and administratively manageable. Furthermore, given the long-term nature of GME program development, we urge CMS to account for the time hospitals will need to adapt to any policy changes.

i. Comments received by CMS regarding the Accreditation Council for Graduate Medical Education (ACGME) initial accreditation as a consideration for program newness.

In response to the FY 2025 IPPS proposed rule, the AAMC and numerous other GME stakeholders urged CMS to consider the determination of a program's newness, in whole or in part, on whether the program had received initial accreditation from the ACGME. The most objective, transparent, and administratively feasible policy—one universally understood within the GME community—is to rely on initial accreditation or an equivalent determination from an accrediting body. However, if CMS feels that initial accreditation alone is insufficient, we have two recommendations that are discussed in greater detail in sections ii.b. and ii.c. below. The AAMC and our member institutions feel that initial accreditation from ACGME should adequately demonstrate that the program is "truly new."

First, accreditation is the criterion CMS uses to define an "approved program." Given that only approved programs qualify for Medicare GME reimbursement, it is surprising that CMS would not place weight on the accrediting body's judgment regarding a program's newness. Since CMS already depends on accreditation to determine program eligibility for reimbursement, it seems logical that initial accreditation should play a central, if not decisive, role in determining whether a program is new.

Second, the initial accreditation process involves an exhaustive review of the program, examining its history, financial stability, the qualifications of program directors and teaching faculty, and the availability of necessary training opportunities at appropriate clinical sites. This comprehensive evaluation, conducted by an ACGME Review Committee, scrutinizes every aspect of the program before granting initial accreditation. Additionally, all new residency and fellowship programs must undergo an accreditation site visit prior to review by the applicable Review Committee. This process, which can take up to a year, is far more detailed and rigorous than what CMS or a Medicare Administrative Contractor (MAC) could reasonably undertake.

ii. Requiring that 90% of residents not have prior training in their program specialty, could create a bright line threshold for CMS to evaluate whether a program is new.

a. Transition from factor analysis to an elements test, or a "bright line rule."

As discussed in greater detail under Section (iii.), CMS appears interested in moving away from its current policy, which could be characterized as a factors analysis, to an elements (or bright line) test. The distinction is critical for stakeholders to understand. A factors analysis relies on the weighted consideration of various factors to determine, in this case, whether a program is "truly new." In contrast, an elements test may fail if even a single required condition is unmet. Because of ambiguity in the current weighting factors, greater clarity in determinations of newness is welcome. A drawback to a bright line test, though, is that extenuating circumstances beyond the control of a program or hospital can cause a program to fail a necessary element and lose a determination of newness.

The reality is that most hospitals are intensely focused on maintaining accreditation, as they should be, which can lead to operational circumstances that need to be cured during the natural course of running a program. For instance, it is common for program directors or core faculty to change roles or move on to other positions during the five-year cap-building window. ACGME mandates these roles, and finding replacements can be difficult, especially for smaller specialties and rural programs. It is also common for residents to transfer during the course of training. If a resident leaves their second year, a program will likely look for a post-graduate year (PGY) 2 resident from another program in the same specialty. Another consideration for smaller programs is that they may be in a specialty required to maintain a minimum cohort for each PGY. Any policy that adds unnecessary complexity or burden will not serve the broader goals of improving future access to care. It is crucial that any changes be thoughtful and balanced to promote both high-quality program development and ensure compliance.

b. 90% newness of residents requirement ("90% rule").

CMS proposed that a program can be considered new if at least 90% of its residents—"new residents"—lack prior experience in the program specialty. The AAMC recognizes CMS's desire to create a bright line rule, independent of accreditation, to determine whether a program is new. However, we note that residents are typically matched into residency programs, and those with advanced training are often brought in to provide stability during a program's early years. In many cases, having residents with prior experience supports the program's ability to meet the educational standards required for accreditation by having senior residents who can provide intern supervision. Additionally, there is societal value in allowing displaced residents to continue training within the same community.

Demonstrating that 90% of residents have no prior training would, alone, indicate that a program is new for CMS's purposes. However, for small programs, even a few residents with prior experience could cause the program to fall below the 90% threshold. While CMS suggested in the proposed rule that a minimum of 16 residents is needed to establish a new program (primary care specialties), the AAMC points out that 16 represents the absolute minimum. For example, a psychiatry program with the smallest cohort possible would have only 15 distinct residents over

five years. Adding just one resident per PGY year would increase the total to 20. We suggest CMS consider a threshold of greater than 22 residents when applying the 90% rule to ensure that smaller programs, which typically matriculate only a few residents each year, can still be considered "new" even if they do not meet a 90% threshold.

Furthermore, CMS should adjust the 90% threshold to a more manageable level for smaller programs that may rely on a few experienced residents to ensure program stability. The 90% figure stems from the standard used in Section 5506 redistributions, but for smaller programs, CMS should consider a majority threshold—such as 50% or 60%—of residents having no prior experience in the specialty. This lower threshold would maintain the spirit of this requirement, while allowing for flexibility where it is necessary.

In applying the 90% rule, CMS should consider some exceptions for residents with prior experience in the same specialty, particularly those who are displaced from closed hospitals or programs and residents from preliminary or transitional year programs. There is societal value in allowing displaced residents to complete training near a closed hospital. CMS could identify displaced residents and "firewall" them from adding to the new teaching hospital's FTE cap. If a sending hospital closes, there would be an opportunity through Section 5506 to receive those slots permanently.

Transitional or preliminary-year residents should also be considered new and included in the cap-building determination for new teaching hospitals, even if they have prior experience in the same specialty. These residents entered programs expecting to find a second program to furnish the remainder of their training. The prior experience these residents have does not constitute a transfer of a program, and because these residents and the programs they matriculate from are easily identified, it should be of little burden to CMS to implement this exception.

A 90% rule could be administratively feasible and transparent with appropriate checks and balances. While CMS has concerns about using initial accreditation from ACGME, a program with initial accreditation and meeting the 90% threshold (or a lower threshold for smaller programs) should assure CMS that the program is new. As stated earlier, CMS should also allow for a reasonable review process when extenuating circumstances cause a program to fall below the threshold requirement, ensuring that such programs are not unfairly disqualified from being considered new.

c. The 90% rule with enhanced review.

If CMS is not satisfied with a 90% rule (as described above), it could implement a more detailed policy, requiring the Medicare Administrative Contractor (MAC) to conduct an "enhanced review" of residents with prior experience in the same program specialty and cross-check these residents with the backgrounds of program directors and core faculty (the "program administration"). Overlap in experience between residents and program administration could be assessed to ensure that a transfer of a program did not occur. The AAMC would request that CMS only consider the program director and core faculty for overlap review. The administrative burden of tracking all faculty over each resident's tenure at a training institution would be untenable.

For example, a new internal medicine residency program at Hospital A takes an internal medicine PGY-2 resident from Hospital B and hires a hospitalist from Hospital B as core faculty (who was not core faculty at Hospital B's internal medicine residency program during the resident's PGY-1 year). Under "enhanced review," CMS or the MAC would review the resident, core faculty, and program director experience for an overlap to ensure that this was not a transfer of a program. In this case, no overlap occurred since the physician was not a core faculty member at Hospital B's internal medicine program for this resident during their training at Hospital B. However, if the physician had served as core faculty or program director during the resident's time at Hospital B, CMS could disqualify the resident from counting toward the new teaching hospital's FTE cap.

To further address cases of overlap, CMS could allow programs to demonstrate that the original residency program (Hospital B's internal medicine program) remained operational for a reasonable period after the resident transferred to Hospital A. Because CMS's concern is the transfer of programs, a hospital that can establish that the program a resident came from is still intact for some time after the resident begins training in the new program would have strong evidence that the programs were not transferred. Some commenters have suggested a one-year timeframe, which seems reasonable. This approach would help mitigate concerns about program transfers while allowing new programs to establish themselves within CMS's criteria.

iii. Requests for information, program director, and faculty "newness."

In the FY 2025 IPPS proposed rule, CMS solicited feedback on new policies for residency programs, including the possibility of requiring that the program director or faculty members have no prior experience in those roles or that there be no or minimal overlap in experience between program director and faculty. To reiterate, CMS—a federal regulatory agency—suggests a policy prohibiting new residency programs from hiring individuals with prior experience running or managing such programs. On its face, this proposal would jeopardize the quality of care, patient safety, training, and educational experience of residency programs.

No CMS policy should compromise a residency program's educational stability or soundness. Limiting a hospital to only hire program directors and faculty with no direct experience in their role's verges on negligence. While such a restriction might be administratively simple for CMS, it is fundamentally flawed. A new teaching hospital already faces significant challenges in developing the infrastructure necessary to meet accreditation standards and ensure patient and resident safety. Imposing restrictions on hiring experienced leaders, or leadership that might have overlap in experience, in key roles is unnecessary and could threaten the program's ability to maintain accreditation. Having experienced personnel in such critical positions is essential, particularly when these new programs are often housed within hospitals with no experience integrating and running residency programs.

Under CMS's current rules for determining program newness, a set of factors—including the experience of program directors and faculty—is considered, with "newness" in these roles being balanced against other criteria. CMS is now proposing to replace this factors analysis with an elements test, which would remove the flexibility of interpreting the relative importance of these

factors. While the AAMC maintains that the FY 2010 IPPS final rule does not adequately explain CMS's *nonstandard* definition of what "new program director" or "new faculty" means, the current factors analysis allows for other considerations to carry weight and for programs to receive a determination of "newness" even if the program director or faculty has prior experience. CMS should take no comfort that hospitals' compliance with the FY 2010 "newness" factors analysis assures the viability of a bright line "newness criteria" element test based on CMS's definition of "new program director" or "new faculty."

CMS must not propose or finalize a policy that requires program directors or faculty to lack prior experience as program directors or faculty.

iv. Commingling of Residents

For new residency programs—particularly smaller programs and those in rural or underserved areas—shared rotations with established programs are essential to meeting educational requirements, not an opportunity to build additional cap space at another hospital. It is incumbent upon CMS to demonstrate that there is a real issue here beyond a few hypothetical scenarios. The AAMC does not believe that teaching hospitals are abusing the system, and policy changes that chill the ability of new programs to meet educational requirements are unacceptable.

CMS appears to misunderstand the motivations of new teaching hospitals, as the examples cited in the proposed rule assume that institutions are attempting to "game" the system to create additional cap space in existing programs. The creation of additional cap space for residents from new programs is directly proportional to the time they spend at the new teaching hospital or other eligible hospitals. For new teaching hospitals, any time residents spend at another hospital permanently reduces its own FTE cap. Under these circumstances, there is no incentive for new programs to place residents in established programs beyond the necessity of meeting accreditation requirements. In fact, new teaching hospitals are incentivized to limit the time residents spend at other institutions as much as possible.

For CMS's "extreme example," it is crucial to clarify how such a program would maintain accreditation. Has this scenario occurred, or is it purely hypothetical? If the latter, it raises the question of why CMS is developing public policy based on an unlikely situation. Public policy should be grounded in real-world data and concerns, not in addressing hypothetical issues that are exceedingly rare or unworkable.

v. Hospitals that operate two programs in the same specialty.

The AAMC reiterates its previous comments on the issue of hospitals sponsoring two residency programs in the same specialty. Stakeholder feedback has underscored the need for certain hospitals, particularly rural hospitals, to operate two programs in the same specialty. In these cases, having two distinct programs is not an attempt to circumvent existing rules or artificially inflate the FTE cap but rather a practical necessity driven by factors such as geographic reach, subspecialty focus, or the need to meet the demand for residency training in high-need areas.

If CMS intends to pursue policy modifications in this area, it must first demonstrate the current system's specific challenges or abuses. Absent compelling data, instituting overly restrictive policies could unnecessarily burden hospitals acting in good faith to meet the needs of the communities' future workforce demands. By focusing on documented concerns rather than hypothetical scenarios, CMS can ensure that any new policy avoids unintended consequences that might hinder hospitals' abilities to train the next generation of physicians effectively.

Thank you for the opportunity to comment on this RFI. The AAMC is happy to work with CMS on any comments discussed in this letter or other topics involving the academic medicine community. If you have questions regarding our comments, please feel free to contact Bradley Cunningham at bcunningham@aamc.org.

Sincerely,

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cc: David Skorton, M.D., AAMC President and Chief Executive Officer