AACOM
American Association of Colleges of Osteopathic Medicine

October 15, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Program Newness Request for Information

Dear Administrator Brooks-LaSure:

The American Association of Colleges of Osteopathic Medicine (AACOM) appreciates the opportunity to respond to the request for information on new residency program standards included in the Centers for Medicare and Medicaid Services' (CMS) fiscal year (FY) 2025 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule.

Osteopathic medicine represents a whole-person, patient-centered approach to the practice of medicine. AACOM leads and advocates for osteopathic medical education (OME) to improve the health of the public. Founded in 1898 by the nation's osteopathic medical schools, AACOM represents all 42 colleges of osteopathic medicine (COMs) — educating more than 36,500 future physicians, 25 percent of all US medical students — at 67 medical school campuses, as well as osteopathic graduate medical education professionals and trainees at US medical centers, hospitals, clinics and health systems.

AACOM reiterates its recommendation from the FY25 IPPS Final Rule that new resident criteria apply only to the PGY1 year of training, extending for the entire cap-setting period for that program (five years).

The proposed 90 percent threshold for 'new' residents severely limits residents' ability to transfer and for new programs to fill unexpected vacancies. This is detrimental to the program needing the resident and to the resident, who almost always has compelling reasons for requesting the transfer. Adding PGY2 transfers with experience in the specialty to a program in its first year can also add sustainability and help jump start small rural programs. Transfers are also often necessary for programs in specialties such as Family Medicine, which may have to backfill their PGY2 class to account for vacancies created by residents who transfer to a program in another preferred specialty after their first year. Limiting the 'new' resident criteria to only those in their first year of training will assist new rural programs in getting off the ground and allow programs to fill vacancies while also ensuring new programs are not one-for-one replacements of existing programs.

AACOM also recommends that the 90 percent threshold be adjusted to 25 percent for small programs. The proposed 90 percent threshold is untenable for small programs, given that a

single resident who is not new would put the program below it. When combined with our recommendation above, our proposed 25 percent threshold would ensure that at least one resident in PGY1 is new to the specialty.

Any regulations developed by CMS should not unduly impede the development residency programs in rural and underserved areas. As the nation faces a particularly acute shortage of physicians, especially those in primary care, it is critical that CMS not create additional burdens for smaller residency programs in rural and underserved communities. The Accreditation Council for Graduate Medical Education (ACGME) already imposes standards on small and rural programs that make the creation of new rural programs more onerous. Adding additional requirements through CMS will further hinder the creation of new residency programs in these underserved areas.

AACOM understands that CMS desires to reach consensus more easily on this important matter, and we have reviewed other comments and summaries provided by CMS. Therefore, as an alternative, **AACOM would also support exemptions from any 'new program' rules around residents, faculty and Program Director for all programs primarily training in rural locations and small programs training primarily in urban underserved facilities.** These programs have unique characteristics and challenges associated with undertaking the start of a new residency program. New programs in rural and underserved areas enroll residents from many places, including transfers from other programs in the same specialty. CMS should do all it can to encourage the growth of these small and rural programs and should consider exempting them entirely from the new program definition.

Further, if additional time is needed to address whether a program is 'new,' **AACOM supports the use of a safe harbor provision** to allow new programs to operate separately but concurrently with existing programs that link previously to the program director, faculty and residents. Under this proposal, a program would be deemed 'new' when it receives its new accreditation, even if the program director, faculty and/or residents previously worked and/or trained at one or more other program, so long as all of those other source programs continue to operate as existing program(s) for the first year of the new program. With both programs operating simultaneously, it is clear that the new program could not be a relocation of the existing program because they both operated concurrently.

AACOM appreciates your consideration of our recommendations and stands ready to partner with CMS in your efforts to strengthen and improve the nation's GME system. If you have any questions or require further information, please contact me at dbergman@aacom.org.

Best,

David M Bergman

David Bergman, JD
Senior Vice President of Government Relations and Health Affairs
American Association of Colleges of Osteopathic Medicine