National Rural Health Association

February 13, 2023

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

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is writing to raise our concerns about the low number of rural hospitals that received Medicare graduate medical education (GME) slots from the recent award of 200 slots established by the Section 126 of the Consolidated Appropriations Act (CAA), 2021.

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

Last month, CMS awarded the first 200 of 1,000 Section 126 Medicare-funded full-time equivalent (FTE) GME slots to 100 different hospitals. The CAA, 2021 mandated that at least 10% of all slots go to four different categories of hospitals. Two of the categories are rural hospitals or hospitals in areas treated as rural and hospitals in Health Professional Shortage Areas (HPSAs). CMS indicated that it prioritized hospitals in areas with the most need as determined by HPSAs. **However, NRHA is troubled that in the first round, only 5 rural hospitals received slots.** We want to flag this number for CMS and lay out potential explanations for why so few rural hospitals received Section 126 slots.

NRHA believes that there is a myriad of reasons why rural hospitals may have received so few GME slots. First, there may be an issue with awareness and outreach surrounding the Section 126 slots. While the number of awards to rural hospitals is low, the number of rural hospitals that applied was also low. It is our understanding that only 9 rural hospitals applied for Section 126 slots. This indicates that rural hospitals may not have known about the opportunity to apply. Over the remaining 4 years of distribution, CMS should prioritize outreach to rural hospitals on this opportunity. We believe that there are up to 80 existing rural residency programs that are at their GME cap and therefore may be incentivized to apply for slots. Further, the low volume of rural hospital applicants may also signal a lack of resources. NRHA believes that some rural hospitals may not have the capacity to take on additional residency slots.

Of note, NRHA is very concerned about the impact of urban hospitals reclassified as rural on the Section 126 slot distribution, and GME slot distribution in general. The CAA, 2021 notes that hospitals located in a rural area, defined by § 1886(d)(2)(D) of the Social Security Act or treated as being located in a rural area, defined by section § 1886(d)(8)(E), are eligible to receive rural slots. Hospitals treated as being located in a rural area means urban hospitals that have reclassified to rural

status. NRHA understands that this is a statutory requirement but believes that reclassified hospitals frustrate the goal of Section 126 slots.

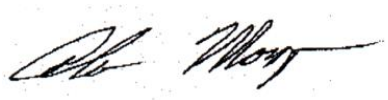
Hospitals have been able to take advantage of reclassifying as rural for geographic purposes while at the same time receiving higher reimbursement by reclassifying their wage index back to urban. In 2015, the United States Court of Appeals, Third Circuit decided in *Geisinger vs. U.S. Department of Health and Human Services* that this practice of reclassifying from an urban to a rural geographic classification, and subsequently reclassifying back to urban for payment purposes, is legal. This creates a more favorable reimbursement rate for the hospital while retaining the ability to receive rural GME slots. These hospitals will likely see continued awards of GME slots without furthering the statutory intent of expanding training in rural, medically underserved areas.

Additionally, there are approximately 80-90 rural referral centers (RRCs) that are considered rural under § 1886(d)(8)(e) that are located in rural areas. The remaining RRCs are urban hospitals that can be counted as rural for certain purposes, and thus pose another threat to hospitals in rural areas in the distribution of slots. Theoretically, if all of these RRCs applied for Section 126 slots, this would account for the entire 10% of the statutorily required rural set-aside for slots, without any of the slots actually being allocated to facilities in rural areas.

Considered together, NRHA believes that the reasons above explain the low number of rural hospitals that received Section 126 slots. This will continue to be a concern of ours as the next four years of awards are rolled out. While the CAA, 2023 increased the number of psychiatry and psychiatry subspecialty GME slots, again with a 10% rural set-aside, we are concerned similar challenges will remain, particularly related to reclassified facilities. When these slots are distributed beginning in fiscal year 2026, we anticipate a similarly low number of rural hospitals receiving the slots. **We would welcome a chance to meet with the appropriate CMS staff to discuss what we know about the small number of GME slots awarded to rural and potential solutions.**

NRHA thanks CMS for its continued support of rural communities across America. We look forward to working towards our mutual goal of improving quality and access to care. If you would like additional information, please contact Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association