aacom
AMERICAN ASSOCIATION OF
COLLEGES OF OSTEOPATHIC MEDICINE

OFFICE OF THE PRESIDENT

August 30, 2010

Donald M. Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1504-P
P.O. Box 8013
Baltimore, Maryland 21244-1850

RE: Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Res; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Proposed Changes to Payments to Hospitals for Certain Inpatient Hospital Services and for Graduate Medical Education Costs; and Proposed Changes to Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations, 75 Fed. Reg. 46170 et seq. (Aug. 3, 2010) (CMS-1504-P)

Dear Dr. Berwick:

On behalf of the American Association of Colleges of Osteopathic Medicine (AACOM), I am pleased to submit comments on the CY 2011 Hospital Outpatient Prospective Payment System proposed rule, specifically the implementation of graduate medical education (GME) provisions of the recently passed Patient Protection and Affordable Care Act (ACA). AACOM represents the administrations, faculty, and students of the nation's 26 colleges of osteopathic medicine and four branch campuses that offer the doctor of osteopathic medicine degree. Today, more than 18,000 students are enrolled in osteopathic medical schools. Nearly one in five U.S. medical students is training to be an osteopathic physician, a ratio that is expected to grow to one in four by 2019.

Counting Resident Time in Nonprovider Settings

AACOM applauds Congress for including the provision in ACA with regard to counting resident time in nonprovider settings for GME and Indirect Medical Education (IME) payment purposes. This provision clarifies the requirements for counting residents training in nonprovider sites and we are pleased with the proposed implementation of this provision. This change was necessary because of the importance of exposing residents to settings other than the hospital to adequately gain relevant clinical experience and prepare for situations they will encounter in practice. Furthermore, AACOM cannot stress how important it is for the GME program to recognize and adapt to the limited training options in some geographic areas, which tend to be in the greatest need of an increase supply of practitioners, and in many instances, are where graduates of osteopathic medical colleges practice.

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The ACA requires the creation of recordkeeping requirements for training in ambulatory settings. The proposal requires data for primary care residents to be reported by primary care specialty and data for other specialties to be reported on an aggregate basis. Primary care residents are defined as residents in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or "osteopathic general practice." The term "osteopathic general practice" applied when osteopathic physicians entered general primary care practice after completing an internship but without a family medicine residency. Currently, osteopathic graduates complete a traditional rotating internship when entering residencies that require an initial year of broad-based general training. AACOM believes that the requirements should reflect the current state of training and "traditional rotating internship" should replace "osteopathic general practice

Counting Resident Time for Didactic, Scholarly and Other Activities

As dictated by the ACA, the proposed rule implements a provision to clarify and extend the rules for counting the time residents spend in didactic activities, including conferences and seminars, in both hospital and nonhospital settings. The change allows the time spent by residents to be counted towards Direct Graduate Medical Education (DGME) if they occur in a hospital, hospital-based provider or subprovider or a nonhospital setting "primarily engaged in furnishing patient care." For IME purposes, time spent could be counted in hospital or provider-based hospital outpatient departments, but not in a nonprovider setting. Research activities not associated with the treatment or diagnosis of a particular patient may not be counted for DGME or IME regardless of location. AACOM is pleased to see these changes implemented since both didactic and clinical experiences play a vital role in resident training. Traditionally, AACOM has recognized that medical training is greater than just clinical experiences, if as a nation, we want to train well rounded, culturally sensitive physicians; this regulation demonstrates that the GME system has the same goal.

Redistribution of Residency Slots

The ACA required 65 percent of unused residency slots to be redistributed and 75 percent of those redistributed slots to be dedicated for primary care or general surgery residencies. If a hospital's "reference resident level" is less than its full time equivalent (FTE) resident limit, 65 percent of the difference will be eligible for redistribution. The proposed rule outlines the method to be used for cap reductions, exemptions, and the application process to redistribute unused slots.

Cap Reductions

The proposed rule articulates how Medicare contractors will be responsible for determining cap reductions on a hospital by hospital basis, even in instances where the hospital is a member of a Medicare GME affiliated group. AACOM requests that CMS reconsider this policy; we believe that the statutory language will have an impact not just on the individual hospital, but will have unintended consequences for other hospitals in the affiliated group. Many teaching hospitals affiliated with colleges of osteopathic medicine train residents in rural and underserved areas. While rural hospitals with fewer than 250 acute care inpatient beds will be exempt, other hospitals in rural and underserved areas may be negatively impacted. If these hospitals and the affiliates in which they are members lose residency slots because of these changes, the result could further limit patients' access to care in areas where more providers are critically needed. We respectfully request that CMS reconsider this proposal to ensure that areas served by osteopathic training programs in greatest need of physicians are not limited.

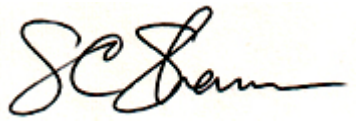
Cap Increases
When redistributing residency positions, CMS must consider if a hospital has a rural training track program and redistribute 70 percent of the slots to hospitals located in states with resident-to-population ratios in the lowest quartile and 30 percent of the slots to hospitals in the states in the top 10 in terms of population living in health professional shortage areas (HPSAs) compared with total population, and to hospitals in rural areas. However, redistributed positions could not be aggregated under a Medicare GME affiliation agreement. We are concerned about this limitation because it seems contradictory to allow these affiliated programs to lose slots, but not gain them when they meet the redistribution criteria. This policy will restrict collaborative training agreements, which are so vital for residency training in rural and underserved areas. AACOM urges CMS to reconsider this proposal and not limit resident training in rural areas, which Congress sought to promote in ACA.

Resident Positions from Closed Teaching Hospitals
Before the passage of ACA, if a teaching hospital closed, its direct GME and IME FTE resident cap slots would be "lost," because those slots are associated with a specific hospital's Medicare provider agreement. AACOM strongly supports the provision to address this issue, included in ACA, that require the Secretary of the Department of Health and Human Services to develop a process for distributing the FTE residency caps of teaching hospitals that close on or after March 23, 2008, to other nearby hospitals. This replaces the previous policy of temporarily increasing the FTE resident cap of hospitals that accommodate the residents. This policy change will enhance future access to care and ensure that physician workforce difficulties, beyond those already associated with a hospital closure are addressed. Additionally, we strongly support the revised definition of closed hospitals to include acquisitions, which provides clarity for hospitals considering new contractual relationships.

Like the redistributed residency positions, closed hospital residency slots could not be aggregated through Medicare GME affiliation agreements. While we, like CMS, want to ensure that these positions remain with hospitals demonstrating need, it is not logical to limit affiliation as Congress recognized and promoted collaborative training relationships in ACA. We request that CMS reconsider prohibiting the affiliation of these residency positions.

Thank you for this opportunity to provide comments on the proposed Medicare GME regulations. If you have questions or require further information, please contact Pamela Murphy, Acting Director of Government Relations, at (301) 968-4151 or pmurphy@aacom.org.

Sincerely,



Stephen C. Shannon, D.O., M.P.H.
President and CEO