

November 4, 2022

*Re: RFI seeking public input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency*

The American Association of Colleges of Osteopathic Medicine (AACOM) thanks you for the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services' (CMS) Make Your Voices Heard: Promoting Efficiency and Equity Within CMS Programs [Request for Information](#).

**Accessing Healthcare and Related Challenges, Including Personal Perspectives and Experiences**

AACOM, as a voice for osteopathic medical education (OME), represents all 38 colleges of osteopathic medicine (COMs) at 62 teaching locations in 34 U.S. states, as well as osteopathic GME professionals and trainees at U.S. medical centers, hospitals, clinics and health systems. To address health workforce needs, AACOM supports:

- 1. The expansion of Medicare-funded graduate medical education (GME) slots and lifting of the statutory cap to ensure the stability and continuity of medical residency programs.**
- 2. Policy solutions to ensure all residency programs are open to osteopathic and allopathic medical graduates.**

AACOM believes that well-trained physicians, particularly in rural and underserved communities, are essential to ensuring that individuals have access to high-quality healthcare. Doctors of Osteopathic Medicine (DOs) are uniquely positioned to address healthcare access and related challenges because:

- COMs are educating nearly 36,500 future physicians, 25 percent of all U.S. medical students.
- More than 7,300 new osteopathic physicians entered the workforce this year, and there has been an 81% increase in the number of DOs and osteopathic medical students over the past decade.
- Osteopathic medical students receive 200 hours of additional training in osteopathic manipulative treatment, a hands-on treatment used to diagnose and treat illness and injury, giving us a unique voice and perspective in the medical community.
- More than half of DOs currently practice in primary care, and 55.1% of U.S. DO seniors matched into primary care residencies this year.
- 59% of COMs are in Primary Care Health Professional Shortage Areas (HPSAs).

- AACOM data show that 41% of graduating 2020-2021 DO students plan to practice in a medically underserved or health shortage area; of those, 49% plan to practice in a rural community.
- 64% of COMs require clinical rotations in rural and underserved areas, giving DO students significant experience training in diverse healthcare settings like community hospitals and other health facilities.
- Physician distribution is influenced by training, and most practice within 100 miles of their residency program.
- In fact, more than 73% of DOs practice in the state where they do their residency training, and that number rises to 86% when they do both medical school and residency in the state.

### **Recommendations for How CMS Can Address These Challenges Through Our Policies And Programs**

**AACOM recommends that Medicare-funded GME programs are required to accept DO applicants and equally accept the United States Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), if an examination score is required.**

- DOs face exclusion and undue burdens when applying for federally-funded residency programs.
- 32% of residency program directors never or seldom interview DO students; of those that do at least 56% require the USMLE. DO students take the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX) for graduation and licensure. DO and MD requirements are parallel, with both medical exams leading to unrestricted physician licenses.
- DO students incur significant financial costs (more than \$6 million a year), as well as the commitment of time and emotional energy, to take the USMLE, which is not designed for the osteopathic profession or needed for licensure or practice.
- These restrictive practices frustrate DO delivery of healthcare services and pose a significant threat to the agency's goal of achieving high-quality, affordable patient-centered care. Moreover, these restrictive practices exacerbate the workforce shortage by forcing DOs to pursue residencies outside their preferred locations, which are often in rural and underserved areas.

**AACOM encourages CMS to prioritize and implement programs that expand residency training in community-based settings, such as rural health clinics, federally-qualified health centers, rural emergency hospitals and other rural hospitals/healthcare facilities. Programs should facilitate streamlined program requirements that impose minimal administrative and regulatory burdens and provide maximum flexibility for participation.**

- Rural hospitals represent more than half of all hospitals in the U.S. and play a vital role in effectively meeting the needs of a community that may otherwise be underserved.
- However, rural hospitals regularly struggle to recruit and retain a healthcare workforce sufficient to meet the needs of the communities they serve, and this challenge has been

further exacerbated due to financial distress and workforce strain intensified by COVID-19.

**AACOM urges CMS to increase access to care in rural and underserved communities and address the maldistribution of GME by:**

1. Lifting the caps and removing Medicare limits on rural resident training growth
2. Extending equitable federal funding to rural hospitals for residency training, such as Sole Community Hospitals and Critical Access Hospitals
3. Increasing support for Medicare reimbursement of urban hospitals that send residents to train in rural healthcare facilities
4. Establishing an elective per resident payment initiative to ensure rural hospitals have the resources to bring on additional residents.

**Factors Impacting Provider Wellness and the Distribution of the Healthcare Workforce**

Osteopathic medicine represents a whole-person, patient-centered approach to the practice of medicine and plays a critical role in our nation’s healthcare delivery system. DO students are taught using a distributed model of medical education where clinical training is received in and from community-based hospitals and physicians, enabling students to learn more about the healthcare needs of the communities where they will eventually practice. The distributed model of OME uses a variety of settings—large and small community hospitals, community health centers and an array of outpatient settings—to teach clinical medicine. It is much more likely that COMs are training physicians in environments where they will practice. Further, clinical training settings often dictate practice location. As previously noted, more than 73% of DOs practice in the state where they do their residency training, and that number rises to 86% when they do both medical school and residency in the state.

There are different models of distribution in OME. Some COMs use a “hub and spoke” model where a campus (often the COM campus) serves as academic home (for academic lectures, simulations, testing, etc.), and students rotate through various smaller affiliated clinical sites. Other COMs have set up clinical campuses, where students spend their full clerkship year(s). Changes in healthcare—such as hospital mergers, increased care in ambulatory settings, reallocation of less complex care from hospitals to community settings and financial pressures on hospitals and other institutions—result in more physicians being trained in a distributed training model. The distributed model of training has been replicated across the OME community and produces strong outcomes, including more primary care physicians in rural areas.

Deans of both MD- and DO-granting medical schools report increased difficulties in recruiting, developing and retaining clinical training sites and clinical faculty. The challenge is greater for COMs because education often occurs at sites that are more rural, remote or difficult to access. The role of the distributed model means faculty are maintaining their medical practice and caring for patients while teaching and sometimes engaging in research. Although these sites offer benefits of exposing students to the unique needs of a wider range of populations, faculty lack financial support compared to academic health centers where they can be supplemented through Medicare funding.

Financial support for faculty is critical. Research on the motivations of clinical preceptors who teach medical students cite internal motivation as the driving force over external motivators (like increased pay, benefits or honors and other supports). However, practical supports for clinician-educators are important. Teaching students impacts a practicing physician's productivity so developing and maintaining these motivators in a busy practice is daunting. This has led to a clinical rotation "arms race" of ever-increasing costs for both recruitment and compensation of teaching physicians. In fact, the Advisory Committee on Interdisciplinary, Community Based Linkages recommended a National Center of the Health Resources and Services Administration to support site development with a focus on preceptor recruitment and support.

### **Recommendations for CMS Policy And Program Initiatives That Could Support Provider Well-Being and Increase Provider Willingness to Serve Certain Populations**

As CMS implements this important initiative, AACOM encourages continuous input and representation from the OME community. AACOM urges CMS to:

1. Include DOs and OME experts on committees, workgroups and task forces associated with this initiative to reflect the 80 percent of care delivered in community settings and ensure the osteopathic model of training primary care physicians is incorporated into all policies and programs.
2. Increase funding and establish programs that support and expand clinical rotations and residency training for medical students in community-based settings, such as rural health clinics, federal qualified health centers, rural emergency hospitals and other rural hospitals/healthcare facilities. Programs should facilitate streamlined program requirements that impose minimal administrative and regulatory burdens and provide maximum flexibility for participation.
3. Support evidence-based research for integrative health approaches and recognize the important role of OMT in addressing pain management, musculoskeletal conditions and many other disorders. AACOM encourages the HHS to partner with the osteopathic community as it seeks to develop non-pharmacological and non-invasive treatments for addiction and other chronic medical conditions.
4. Provide financial support to volunteer or uncompensated preceptors to help increase the ability of primary care physicians to provide appropriate, quality ambulatory experiences, especially in rural areas.

### **Advance Health Equity Across CMS Programs by Identifying and Promoting Policies, Programs and Practices That May Help Eliminate Health Disparities**

AACOM believes that increasing diversity in the physician workforce is vital to meet the nation's healthcare needs. The osteopathic medical education community is committed to educating and training more osteopathic physicians who embody the fabric of our nation, not only to address disparities in healthcare, but also to improve the health of all people. COMs are leading the effort to increase diversity in the physician workforce, and as an example we highlight the following programs:

1. The Oklahoma State University (OSU) Center for Health Sciences and the Cherokee Nation (CN) established the OSU Center for Health Sciences College of Osteopathic Medicine at the CN in 2020. Located in Tahlequah, the CN campus is the nation's only tribally affiliated COM. OSU-COM CN is dedicated to educating primary care physicians who have an interest in serving rural and Native American populations in Oklahoma, which ranks 46th in the nation in the number of primary care doctors per capita.

The CN campus matriculates approximately 50 students each year. Nationally, only 0.2 percent of medical school students are Native American. The inaugural Class of 2024 at the CN campus is 22.5 percent American Indian/Alaskan Native (AI/AN) and 31.5 percent underrepresented minorities in medicine. A majority of students (90.7 percent) are from Oklahoma, 38.8 percent are from rural communities and 50 percent are female. For the Class of 2025, 24.5 percent of students are AI/AN, 32.1 percent are underrepresented minorities in medicine, 90.6 percent are from Oklahoma, 45.8 percent are from rural communities and 56.6 percent are female.

Students may pursue a Tribal Medical Track (TMT) that stresses the unique nature and characteristics of practicing within a tribal healthcare system or Indian Health Services facility. A key facet of the TMT is clinical training and experience in a variety of tribal healthcare systems. OSU-COM has active clinical partnerships with the CN, Choctaw Nation, Chickasaw Nation, Indian Health Services and other federally recognized tribes in Oklahoma, increasing the likelihood that students will practice in these communities.

2. The Cleveland Clinic Physician Diversity Scholars Program, a partnership with the Ohio University Heritage College of Osteopathic Medicine (OUHCOM). The Physician Diversity Scholars Program takes a proactive approach to building diversity by giving first-year URM students a unique opportunity for growth and engagement. Those selected to participate in the four-year program are matched with a Cleveland Clinic health system physician with whom they will have an opportunity to develop a mentor/ scholar relationship. The program is designed to complement each scholar's curriculum at OUHCOM while offering purposeful and meaningful interaction with underrepresented minority community populations in a healthcare context. As the medical students progress through the program, a portion of their training will be provided at Cleveland Clinic hospitals and family health centers. The Physician Diversity Scholars program is open to all underrepresented minority medical students at OUHCOM, Cleveland. URM for OUHCOM is defined as Black/African-American, Hispanic/Latino, Native American/Alaskan Native, and Pacific Islander/Native Hawaiian.

### **Recommendations for How CMS Can Promote Efficiency and Advance Health Equity Through Our Policies and Programs**

AACOM recommends CMS consider these osteopathic initiatives as models for national diversity, equity and inclusion policies and programs. Moreover, as research indicates that medical students who train in community-based institutions are more likely to practice in these areas, AACOM urges CMS to support research opportunities for and partner with community-based institutions and osteopathic medical schools in rural locations. These rural training experiences are especially important as our nation faces a growing physician workforce shortage,

particularly in rural communities often subject to increased health care challenges and social risk factors.

### **Impact of COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities**

The osteopathic community is on the front lines of the battle against COVID-19. Osteopathic medical educators and students continue to serve as first responders in medical facilities across the country and are helping to treat COVID patients. During the initial stages of the COVID-19 pandemic, AACOM spearheaded the formation of Students Assist America, an interprofessional initiative of 12 associations and successfully advocated for a Seventh Amendment to the Public Readiness and Emergency Preparedness (PREP) Act Declaration authorizing students from designated health professions to administer COVID-19 vaccinations.

### **Recommendations for CMS Policy and Program Focus Areas to Address Health Disparities, Including Requested Waivers/Flexibilities to Make Permanent; and Opportunities for CMS to Reduce Any Health Disparities That May Have Been Exacerbated by the PHE**

AACOM recommends the Seventh Amendment PREP Act Declaration is made permanent to ensure students from designated health professions are eligible to administer COVID-19 vaccinations and other vaccinations during future federally declared public health emergencies (PHEs).

- The Seventh Amendment to the PREP Act Declaration opened the door for almost one million skilled medical, nursing, pharmacy, dental, veterinary, PA, optometry and other health professions students to administer COVID-19 vaccines with supervision.
- The PREP Act Declaration and subsequent amendments will expire at the end of the current PHE and HHS should make the changes permanent, so it is not forced to go through the arduous amendment process in the next PHE.