

February 25, 2022

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: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; Changes to Medicare Graduate Medical Education Payments for Teaching Hospitals; Changes to Organ Acquisition Payment Policies

Dear Administrator Brooks-LaSure:

On behalf of the American Association of Colleges of Osteopathic Medicine (AACOM), thank you for the opportunity to provide comments in response to the *Centers for Medicare and Medicaid Services' (CMS) fiscal year 2022 Inpatient Prospective Payment Services (IPPS) Final Rule*. As you develop new graduate medical education (GME) proposals, AACOM encourages you to continue obtaining input from the osteopathic medical education community.

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. It is the fastest growing medical field in the country according to the U.S. Bureau of Health Professions. Founded in 1898 to support and assist the nation's osteopathic medical schools, AACOM represents all 38 accredited colleges of osteopathic medicine (COMs)—**educating nearly 34,000 future physicians, 25 percent of all U.S. medical students—at 59 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.

Importantly, the osteopathic community has a proven history of addressing unmet healthcare needs, including in rural and underserved areas and primary care. Fifty-six percent of DOs practice in primary care. Moreover, forty-one percent of graduating 2020-2021 osteopathic medical students plan to practice in a medically underserved or health shortage area; of those, 49 percent plan to practice in a rural community.

AACOM strongly supports provisions in the Final Rule that seek to address the maldistribution of GME and increase access to care in rural and underserved communities including:

- *Reserving at least 10 percent of the new GME slots for rural areas:*
 - AACOM applauds CMS for finalizing this proposal, which we believe will have meaningful impact on access to care.

- Physician distribution is influenced by training, and most practice within 100 miles of their residency program. In fact, over 86 percent of osteopathic medical students who attend medical school and do residency training in a state will practice in that state.
- *Maintaining the hospital eligibility criteria for those applying for new GME slots:*
 - AACOM supports the hospital eligibility criteria for those applying for the new GME positions, and we thank CMS for modifying requirements to expand the definition of the fourth category so that hospitals may count training time in non-provider-based facilities (such as critical access hospitals, rural health clinics, and FQHCs).
 - AACOM previously expressed concerns that the definition in the proposed rule would exclude community-based settings that often serve as primary care training locations for family medicine.
 - Because many COMs include a community-based primary care rotation in a rural or underserved area as a fourth-year training requirement, DO students gain significant experience training in diverse healthcare settings, such as community hospitals and other health facilities, and we are pleased to these sites included in the expanded definition of the fourth category.
- *Prioritization of applications from hospitals that serve underserved populations:*
 - AACOM commends CMS for prioritizing residency programs in rural areas to reduce financial vulnerability and promote greater training of physicians in rural hospitals.
 - Rural hospitals represent more than half of all hospitals in the U.S., yet they struggle to recruit and retain a health care workforce sufficient to meet the needs of the communities they serve due to financial distress.
 - AACOM believes that using geographic HPSAs and population HPSAs for prioritization of applications will help ensure a sufficient physician training pipeline for rural and underserved areas.
- *Increasing maximum award sizes to 5.0 full-time equivalents (FTEs) per hospital per year:*
 - AACOM appreciates CMS' consideration of our comments that the proposal to limit each individual hospital to no more than 1.0 FTE per year would be insufficient to support a new residency program, disproportionately burdening rural and underserved areas.
 - The Final Rule provides more flexibility and financial support for smaller hospitals seeking to become a teaching hospital.
- *Adjusting application deadlines for qualifying hospitals to apply for the new GME slots:*
 - AACOM is pleased that CMS reviewed our recommendation and accounted for the timing of accreditation decisions for new programs when setting application deadlines.
 - AACOM believes the adjusted deadlines will provide more flexibility and accommodate the differing fiscal years between hospitals and accreditation programs.

CMS Solicits Comments to Inform Potential Future Rulemaking

1. How to account for health care provided outside of a Health Professional Shortage Area (HPSA) to HPSA residents, and feasible alternatives to HPSA scores as a proxy for health disparities in the prioritization of additional FTE cap slots.

With Fifty-eight percent of COMs located in HPSAs, it is imperative that CMS explore alternative scoring and account for additional delivery of healthcare services to HPSA residents. AACOM is pleased that you recognized our support for an ‘*impact factor*’ as it relates to HPSA scoring methodology.

- CMS notes in the Final Rule preamble that, “The use of this additional factor, according to commenters, would help ensure that section 126 of the *Consolidated Appropriations Act of 2021* distributions support physician pipelines that produce lasting benefits for underserved areas.”
- Further, CMS notes that “hospitals should be given priority if their training programs have records of sending residents on to practice in provider shortage areas.”

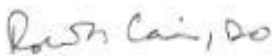
AACOM urges CMS to establish an “impact factor” to prioritize hospitals or programs based on the proportion of their trainees that ultimately go on to practice in HPSAs.

- CMS should collect data on GME trainees to identify those hospitals or programs that place the highest proportion in HPSAs and give preference in new positions to these facilities.
- By adding this “impact factor” to the proposed methodology for prioritizing applications, CMS would also help ensure that the physicians trained using these new residency positions ultimately go on to care for underserved populations throughout their career, not just for the duration of their residency training.

AACOM encourages CMS to use its discretionary authority in future rulemaking to employ regulatory flexibility that supports efficiency, growth and innovation across all aspects of the medical education continuum.

AACOM appreciates your consideration of these recommendations and looks forward to continuing our work with you. If you have any questions or require further information, please contact David Bergman, JD, Vice President of Government Relations, at dbergman@aacom.org.

Sincerely,



Robert A. Cain, DO, FACOI, FAODME
President and CEO