



June 10, 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: Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates.*

Dear Administrator Brooks-LaSure:

The American Association of Colleges of Osteopathic Medicine (AACOM) appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services' (CMS) fiscal year 2025 Medicare Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule and highlight priorities for the osteopathic medical education (OME) community as you develop graduate medical education (GME) policy.

Osteopathic medicine represents a whole-person, patient-centered approach to the practice of medicine. AACOM leads and advocates for OME to improve the health of the public. Founded in 1898 by the nation's osteopathic medical schools, **AACOM represents all 41 colleges of osteopathic medicine (COMs) — educating more than 36,500 future physicians, 25 percent of all US medical students** — at 66 medical school campuses, as well as osteopathic graduate medical education professionals and trainees at US medical centers, hospitals, clinics and health systems.

AACOM urges CMS to implement GME policies that foster training in rural and underserved areas as these communities face persistent shortages of healthcare professionals. COMs prioritize training future physicians in community-based settings and serving disadvantaged populations. Training in these areas directly contributes to the state's healthcare workforce as 86 percent of doctors of osteopathic medicine (DOs) who attend a COM and residency in a state stay to practice in that state. Moreover, 56 percent of COMs are located in health professional shortage areas, 64 percent require their students to go on clinical rotations in rural and underserved areas and 88 percent have a stated public commitment to rural health.

As experts in the distributed model of training, COMs are committed to community-based training, which exposes medical students to the unique healthcare needs of rural and underserved populations and prepares them to serve those communities after graduation. As

CMS implements this proposed rule and other policies, AACOM urges CMS to use its authority to support efficiency, growth and innovation across all aspects of the medical education continuum.

**Proposed Distribution of Additional Residency Positions Under Section 4122 of the Consolidated Appropriations Act, 2023 (CAA, 2023)**

AACOM supports the distribution of the 200 new residency slots, with a focus on psychiatry and psychiatry sub-specialties. However, we are concerned that CMS continues to rely on Health Professional Shortage Area (HPSA) scores as an overarching prioritization for slot distribution. This limits geographically rural hospitals from receiving slots.

Using the current distribution methodology, only seven hospitals in geographically rural areas received slots through the first two distributions under Section 126 of the CAA, 2021, far fewer than the 10 percent in statute. *The vast majority of slots designated for rural areas have instead gone to rural referral centers and other facilities in urban and suburban settings that are "treated as being in a rural area."*

*Pro Rata Distribution*

AACOM supports CMS's distribution plan of allocating up 0.01 FTE to each qualifying hospital. However, AACOM urges CMS not to prioritize distribution of the remaining slots based on HPSA score.

In the first round of Section 126 distribution, 291 hospitals applied for slots. Under the proposed prorated 1 FTE distribution plan, each hospital would have received .68 FTE and left no remaining slots for distribution. This would be extremely detrimental to rural hospitals, which would have to fund the remaining costs themselves. As rural residency programs are less able to shoulder unfunded training compared to large urban academic medical centers, many rural hospitals would be disincentivized from applying. Providing each qualifying hospital with .01 FTE would guarantee that the vast majority of slots are available for distribution based on CMS' prioritization criteria. This would be more favorable to rural hospitals, who likely need to receive 3 – 5 slots (depending on the specialty) to fully fund a resident for the entire residency.

Additionally, CMS should not use HPSA scores to prioritize applicants because it is resulting in many rural hospitals failing to apply for or receive slots, demonstrated by the fact that few geographically rural hospitals have received new slots under Section 126. This was largely due to CMS' choice to use the HPSA score as the primary means to prioritize applicants across categories. Due to their smaller populations, rural communities that add new physicians as faculty and retained residents can significantly shift their HPSA scores or lose their HPSA designation, which can prevent a hospital in a rurally-located area from receiving much needed GME slots based on current CMS policy.

*Distributing at Least 10 Percent of Positions to Each of the Four Categories*

**AACOM supports CMS' proposed amendment to its prioritization methodology for rounds four and five of section 126 of the CAA, 2021 to prioritize hospitals serving geographic HPSAs. Further, we urge CMS to allocate at least 10 percent of remaining slots to geographically rural areas regardless of HPSA score for remaining distributions under Section 126 and Section 4122.**

Currently, CMS' distribution of the remaining Section 126 slots is not projected to meet the 10 percent statutory threshold for slots awarded to hospitals serving a geographic HPSA. Given CMS' consistent use of HPSA score as an overarching prioritization, it is likely that hospitals receiving slots in previous rounds served population HPSAs rather than geographic HPSAs.

CMS is also unlikely to meet the 10 percent threshold for slots awarded to rural hospitals if only geographically rural hospitals are considered. As noted above, only seven geographically rural hospitals have received slots through the first two rounds of Section 126 distribution. Furthermore, only 3 programs that received slots in the second round trained residents for more than 50 percent of the time in a CMS or Federal Office of Rural Health Policy designated rural area. Adjusting the criteria for rural hospitals to only consider geographically rural hospitals and removing the HPSA score threshold for hospitals in this category would help ensure that a sufficient number of truly rural hospitals receive slots.

**Proposed Modifications to the Criteria for New Residency Programs and Requests for Information**

*Definition of a Small Residency Program*

**AACOM supports CMS's proposed definition of "small" residency programs as those with 16 or fewer resident positions. We encourage CMS to limit this definition to programs that train residents for more than half of the time in a geographically rural location and/or in an urban underserved facility, such as a federally qualified health center.**

Programs in geographically rural and underserved areas are more likely to be primary care specialties and face additional administrative burdens that are not faced by small residency programs in other specialties, such as plastic surgery or dermatology, which predominantly take place in larger urban hospitals. As the nation faces a particularly acute shortage of primary care physicians, it is critical that CMS not create additional burdens for smaller, primary care residency programs in rural and underserved communities.

*Newness of Residents*

**AACOM recommends that new resident criteria apply only to the PGY1 year of training, extending for the entire cap-setting period for that program (five years). Additionally, we**

recommend that these criteria be adjusted to 25 percent for small programs to align with the proposed small program size.

The high proposed bar for restricting residents transferring from other programs within the same specialty is counter to the well-being of those residents, and potentially detrimental to both the receiving program needing that resident, and to the resident, who almost always has significant reasons for requesting the transfer. Adding PGY2 transfers to a program in its first year can bring sustainability to small rural programs. Furthermore, both the ACGME and the ABMS Boards already have rules regarding resident transfers in place.

#### *Newness of Faculty and Program Director*

**AACOM reiterates that ACGME has a major role in approving new PDs, and these decisions should remain under ACGME's purview. CMS should not set criteria for newness of faculty or Program Directors.**

Program Directors (PDs) are often very high-pressure, high-turnover positions. For many smaller and rural programs, such as new Rural Track Programs (RTPs), the best person for the RTP PD role in development is often the existing urban PD, while the local site director "learns" the role of the PD under the guidance and mentorship of the urban PD and can assume the position of PD on program implementation. As long as the program director is not simultaneously shared with another residency program, they should be considered "new" for the new program, even if transferring directly from one program to another.

#### *"Newness" of Faculty and Program Director for Small Programs*

**AACOM applauds CMS for recognizing the particular challenges in faculty and program director criteria for rural and small programs. Further, we recommend that both programs primarily training in rural locations and small programs training primarily in urban underserved facilities, be exempt from any newly adopted 'new program' rules around residents, faculty and Program Director.**

*What is a reasonable threshold for the relative proportions of experienced and new teaching staff? Should there be different thresholds for small, which may include rural, residency programs?*

**AACOM recommends that CMS not become involved in decisions related to the relative proportion of experienced teaching staff as no threshold is reasonable. This issue is already regulated by the Accreditation Council for Graduate Medical (ACGME), which determines standards for all residency programs. Our recommendation applies to large, small, and rural programs.**

The limited number of faculty available and willing to teach in residency programs is a national crisis for both existing and developing programs. Faculty work is more challenging and lower

paid than other types of physician work – leading to high turnover. Additionally, faculty deserve the right to change jobs for professional and/or personal reasons. Attempting to restrict that movement disadvantages everyone involved; an unhappy faculty member remaining in a position where there is a poor fit tends to undermine the wellbeing of the program and the residents, as well as the faculty themselves. It is critical that CMS adopt faculty policies that help new programs in this extremely high-need area of program development. No threshold is reasonable or necessary.

*Should a threshold for determining newness of teaching staff for a new program consider only Core Faculty, or non-core faculty (or key non-faculty staff) as well?*

**AACOM recommends that CMS not become involved in decisions related to the relative proportion of experienced teaching staff. No threshold is reasonable or necessary for the same reasons noted above. This issue is already regulated by the ACGME which determines standards for all residency programs.**

Non-core faculty are in short supply, high demand, and essential for accreditation. As previously noted, recruitment of faculty and training sites can hinder GME program development. Thresholds for new teaching staff could limit the options for a rural program that depends on an additional site for the first year of inpatient rotations then moves to outpatient for the additional training. If the faculty at the partner hospital have their own program, it would not allow the partnership and inadvertently hinder development of additional training programs in smaller rural settings. This would adversely impact specialties like primary care, obstetrics and psychiatry, all of which are highly needed in rural communities.

*CMS seeks feedback on its suggestion that 50 percent of the teaching staff may come from a previously existing program in the same specialty, but if so, the 50 percent should comprise staff that each came from different previously existing programs in the specialty.*

**AACOM recommends that CMS not establish the 50 percent threshold for teaching staff coming from existing programs in the same specialty. Should CMS move forward with this threshold, we encourage CMS to only apply it to teaching staff coming from the *same* existing program in the specialty.**

As noted above, there is high demand and short supply for experienced faculty and staff. While we understand CMS' concern that a new residency program recruiting most or all of the experienced staff from an existing program risks the disintegration or closure of that program, we are more concerned that severely limiting new programs hiring opportunities could add a significant burden to the already complicated task of staffing a new residency program.

*In considering whether the presence of a faculty member might jeopardize the newness of a new program, would it be reasonable to consider whether 10 years or 5 years, or some other*

*amount of time, has passed during which that faculty member has not had experience teaching in a program in the same specialty?*

**AACOM strongly recommends that as long as the core faculty members are not simultaneously shared between two programs of the same specialty, they be considered "new" for the new program.**

Few if any faculty would pass a 5 or 10 year abstinence test. For small and rural track programs, there should be flexibilities allowed for shared faculty in training outside of the rural hospital setting.

*Would it make sense to define a similar period of time (for example, 10 years or 5 years) during which an individual must not have been employed as the program director in a program in the same specialty? Should there be a different criterion for small, which may include rural, residency programs?*

**AACOM recommends that CMS not become involved in decisions related to the relative proportion of experienced program directors. This issue is already regulated by the ACGME which determines standards for all residency programs. This proposal would not make sense for any new program of any size or location. Program Directors with either PD or faculty experience are a requirement for accreditation. It would not only prevent new residency programs from developing but would cripple those in early implementation.**

Even more so than faculty, the limited number of physicians qualified to be Program Director in residency programs is a national crisis for both existing and developing programs. Experienced Program Directors are necessary to bring the expertise needed to establish a high-quality new program.

### **Commingling of Residents in a New and an Existing Program**

**AACOM recommends that CMS not become involved in decisions related to "commingling" as long as the programs have achieved separate accreditation by the ACGME. This issue is already regulated by the ACGME which determines standards for all residency programs.**

Sharing between programs is not only common but necessary, and also increasingly required by the ACGME for collaboration between programs in enhancing learning of all residents and faculty. Attempts to restrict "commingling" has the potential for significant harm to the education of residents and fellows and will lead to the creation of distrust and "gamesmanship" around difficult-to-enforce rules.

### **One Hospital Sponsoring Two Programs in the Same Specialty**

**AACOM encourages CMS to leave this decision to ACGME, as there are many circumstances where a hospital may legitimately sponsor more than one program in the same specialty.**

The reasons for a hospital to sponsor two programs in the same specialty include the following:

- A hospital serving a large geographic region, where some training may occur at the same hospital but where the majority of residency training is at entirely different locations between the two programs.
- A hospital sponsoring programs with significantly different training missions and hence curricula requiring separate accreditation, such as suburban-focused vs urban-underserved-focused.
- A hospital sponsoring both a core program and one or more Rural Track Programs that are separately accredited. The RTPs have entirely different missions and curricula for training compared to the core program.
- An Academic Medical Center is often the Sponsoring Institution for many programs in a region, some of which involve little or no training at the sponsoring hospital and some that share rotations that are otherwise hard to establish in most clinical settings – e.g. pediatric intensive care, high volume obstetrics, some surgical/medical subspecialties, inpatient rehabilitation, etc.

### **Additional Recommendation for How CMS Can Address Healthcare Access Challenges**

**AACOM recommends that all Medicare-funded GME programs be required to accept applications from Doctors of Osteopathic Medicine (DOs) and accept the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), if an examination score is required for acceptance.**

DOs face exclusion and undue burdens when applying for Medicare-funded residency programs. According to National Resident Matching Program data, 32 percent of residency program directors never (7%) or seldom (25%) interview DO candidates. More than half (56%) of GME programs that consider DOs mandate that they take the MD licensing exam, the United States Medical Licensing Examination (USMLE). DO students take the COMLEX-USA for graduation and licensure. DO and MD requirements are parallel, with both medical exams leading to unrestricted physician licenses in all 50 states.

Medical school is demanding and osteopathic medical students should not be subjected to the additional 32 hours and \$2,335 (as well as prep costs and time) that are required to take the USMLE, an exam that is not designed for the osteopathic profession or needed for licensure or practice.

Federally-funded Medicare GME programs should not be allowed to discriminate against a class of physicians based solely on degree and exam type. 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 practices



exacerbate the workforce shortage by forcing DOs to pursue residencies outside their preferred locations, which are often in rural and underserved areas.

### **Conclusion**

AACOM appreciates your consideration of our recommendations and stands ready 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 David Bergman, JD, Senior Vice President of Government Relations and Health Affairs at [dbergman@aacom.org](mailto:dbergman@aacom.org).

Sincerely,

A handwritten signature in black ink that reads "Robert A. Cain, DO". The signature is written in a cursive, flowing style.

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