

June 25, 2021

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: CMS-172-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates

Dear Administrator Brooks-LaSure:

The American Association of Colleges of Osteopathic Medicine (AACOM) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) fiscal year 2022 Inpatient Prospective Payment Services Proposed Rule.

Osteopathic medical education (OME) plays a key role in the fabric of our healthcare system and training the future physician workforce. AACOM leads and advocates for the full continuum of OME to improve the health of the public. Founded in 1898 to support and assist the nation's osteopathic medical schools, AACOM represents all 37 accredited colleges of osteopathic medicine (COMs)— **educating nearly 31,000 future physicians, 25 percent of all US medical students**—at 58 teaching locations in 33 U.S. states, as well as osteopathic graduate medical education professionals and trainees at U.S. medical centers, hospitals, clinics, and health systems.

The nation faces a physician workforce shortage, and federal policies must support the educational pathway of the future healthcare workforce. This is particularly critical as it relates to policies that would improve access to healthcare in rural and medically underserved areas where shortages are dire and expected to worsen without effective solutions.

AACOM supports 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. One in four U.S. medical students attends a COM, and that number is growing. According to recent data, AACOM received than 28,000 applicants to osteopathic medical school for the 2020-2021 application cycle, representing a 19.26 percent increase compared to the previous year. Importantly, many osteopathic medical students actively pursue careers in primary care, strengthening the backbone of our nation's healthcare system. In 2021, 55 percent of osteopathic seniors entered primary care specialties, and there has been a 116 percent increase of osteopathic graduates entering primary care since 2017.

We believe the proposed rule contains important steps to expand access to GME, particularly in rural and underserved areas. Further, as CMS implements this proposed rule and other policies, we urge CMS to use its discretionary authority to employ regulatory flexibility that supports efficiency, growth, and innovation across all aspects of the medical education continuum.

Distribution of Additional Residency Positions Under the Provisions of Section 126 of Division CC of the Consolidated Appropriations Act, 2021 (CAA)

Definition of a Qualifying Hospital

AACOM supports the following four criteria proposed by CMS to determine hospital eligibility to apply for new GME slots:

1. Rural hospitals or those with a rural designation
2. Hospitals for which the reference resident level of the hospital is greater than the otherwise applicable resident limit (over cap hospitals)
3. Hospitals in states with a new medical school or branch campus
4. Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs)

AACOM believes that well-trained physicians in rural and underserved communities are essential to ensuring that individuals have access to high-quality healthcare. Nearly 40 percent of physicians practicing in medically underserved areas are DOs. While we support the proposed definition for hospitals located in HPSAs, we are concerned that community-based settings that often serve as primary care training locations for family medicine would be excluded.

Therefore, we recommend adding non-provider-based facilities to the definition to recognize hospitals that may count training time for IME/DME purposes (such as critical access hospitals, rural health clinics, FQHCs, etc.). We support the proposed requirement that at least 50 percent of the residents' training time must occur at the hospital locations within the HPSA.

Importantly, AACOM recommends that CMS add the following criteria to the *Definition of Qualifying Hospital*:

- 5. Small hospitals with less than 250 beds**
- 6. Hospitals with only one residency program**

Small hospitals and those with only one residency program play a vital role in effectively meeting the needs of a community that otherwise may be underserved. It is critical that CMS use its discretionary authority to ensure that these hospitals have access to additional residency slots. Many hospitals across the country find themselves in financial distress as a direct result of the COVID-19 pandemic, especially rural hospitals that may have already been struggling prior to the outbreak. Expanding GME eligibility to these hospitals will help to prevent closures and ensure stability and continuity for both trainees and our nation's medical residency programs.

Further, CMS should consider adding measures that would favor hospitals that propose to add new primary care residency training programs. We believe these additional qualifying criteria will support the physician pipeline and access to care in areas of most need.

Number of Residency Positions

AACOM supports the CMS proposal to limit the number of residency positions distributed to 200 per year beginning in fiscal year (FY) 2023 and to no more than 25 additional residency positions per hospital. CMS also proposes to limit the increase in the number of residency positions made available to each individual hospital to no more than 1.0 FTE each year.

AACOM opposes limiting each individual hospital to no more than 1.0 FTE per year as it is insufficient to support a new residency program, disproportionately burdening rural and underserved areas. Setting a maximum of 1.0 FTE per year would risk limiting new positions to existing residencies and place severe limitations on smaller hospitals seeking to become a teaching hospital. The Accreditation Council on Graduate Medical Education (ACGME) establishes the minimum number of residents a program must maintain in each residency year for most specialties. According to ACGME, family medicine, for example, requires at least four residents per year. Hospitals seeking a new family medicine residency program would be forced to financially support three additional residents in order to gain one GME position or fail to meet ACGME requirements. Small hospitals cannot afford these positions.

Application Process

CMS proposes that applications for new residency positions be submitted by January 31 of the fiscal year prior to the fiscal year in which the new positions would take effect. Accordingly, applications will need to be submitted by January 31, 2022, for a position awarded for FY23.

AACOM is concerned that the proposed system does not take into consideration that residency programs operate on a July 1 – June 30 fiscal year, while hospitals follow the calendar year. The disparity may lead to situations where a hospital cannot get timely responses to coincide with procedural deadlines, such as needing an accreditation decision to move forward with a GME application or a GME application awaiting an accreditation decision. **AACOM urges CMS to consider the timing of accreditation decisions for new programs when determining implementation regulations and to provide flexibility where appropriate to accommodate the differing fiscal years.**

Prioritization of Applications

AACOM supports the CMS proposal to use geographic HPSAs and population HPSAs for prioritization of applications. It is an AACOM priority to ensure preservation of GME positions in rural and underserved communities. Rural hospitals represent more than half of all hospitals in the US, 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. Training facilities in rural hospitals operate on very narrow margins and are cautious to commit to ongoing residency training costs without a stable, predictable source of funding.

Osteopathic physicians make a substantial contribution to primary care and medical care in rural and underserved areas, and we commend CMS for prioritizing residency programs in rural areas to reduce financial vulnerability and promote greater training of physicians in rural hospitals. According to data published in a recent report, osteopathic schools ranked highly among medical schools with the most graduates practicing in rural and underserved areas. Six of the top 10 medical schools with the most graduates practicing in rural areas are osteopathic schools, and

four of the top 10 medical schools with the most graduates practicing in underserved areas are osteopathic schools.

Evidence indicates physicians typically practice within 100 miles of their residency program. Additionally, those residents who have completed training in rural health clinics, FQHCs, or critical access hospitals are more likely to practice in these settings. However, the current training environment does not adequately foster the practice of physicians in medically underserved and rural areas and leads to maldistribution. Over time, the use of geographic HPSAs will put more physicians in areas of need and help correct the maldistribution of physicians. Further, the use of population HPSAs will help improve the health of the public by putting doctors into underserved populations.

AACOM also 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.

Proposal for Implementation of Section 127 of the CAA, “Promoting Rural Hospital GME Funding Opportunity”

AACOM applauds CMS for the work on rural training tracks (RTTs), which we believe will lead to improved opportunities for residents of any specialty to train in rural areas and expand access to care for rural populations.

Restriction to Not Allow Cap Adjustments for Existing “Spokes”

CMS proposes the concept of a “hub and spoke” model where the hub is the urban teaching hospital, and the spoke is the rural training site(s). However, CMS is proposing to not allow an increase to an existing rural RTT “spoke.” CMS states that to do so would render the RTT cap meaningless. This would exclude already existing rural training sites from expanding their caps, while new sites would be permitted to receive a new cap and new funding. **AACOM believes that there is nothing in Section 127 that precludes CMS from providing an opportunity to adjust a cap to allow for expansion of existing rural sites, and we encourage the allowance of this expansion.**

AACOM also encourages CMS to include RTT programs within consortium agreements with urban hospitals for inpatient rotations and FQHC’s for outpatient clinics. This would alleviate the burden of building clinics out for residencies and instead allow work in FQHC’s that have backloads of patients and need more providers. Moreover, this training environment would foster the training of primary care physicians.

Proposal for Implementation of Section 131 of the CAA, Addressing Adjustment of Low Per Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals

AACOM supports the CMS proposals in this section. The adjustment of the PRAs and low FTE resident caps will enable many hospitals that serve a small number of residents to expand their residency programs to more meaningful sizes. There are numerous examples throughout the country of rural or satellite tracks that inadvertently set a PRA and cap two decades ago, but no longer have residents.

CMS proposes to issue instructions to the Medicare Administrative Contractors (MACs) and to hospitals to provide for an orderly process of request and review to receive replacement PRAs. **Given that hospitals and training programs must plan for rotations at these hospitals, AACOM believes that the instructions issued to the MACs and hospitals should be issued as an interim final rule and should allow for public comment.** This is especially important for those hospitals that may have already triggered the reset during this cost reporting period and those affected by the COVID-19 public health emergency.

We are also concerned about urban and rural hospitals that are unaware of any PRA and do not intend to become a teaching hospital. PRAs have not been proactively assigned to every hospital in the US, and under current regulations a PRA of \$0 is only discovered when a resident is first reported on a cost report and the required audit reveals a past incident of resident training for which the hospital claimed no cost. **Therefore, AACOM urges CMS to require the MACs to identify hospitals that would fit the criteria for a PRA reset and communicate that information to the hospitals who would be eligible if a PRA had been set.**

Thank you for the opportunity to share our views. 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