American College of Osteopathic Internists • Stay True to Why You Pursued Medicine

June 24, 2024

The Honorable Ron Wyden
Chair, Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
517 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael Bennet
261 Russel Senate Office Building
Washington, DC 20510

The Honorable Catherine Masto
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Bob Menendez
528 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy, MD
455 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Thom Tillis
113 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Marsha Blackburn
337 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Sens. Menendez, Cornyn, Cassidy, Bennet, Tillis, Cortez Masto, and Blackburn:

The American College of Osteopathic Internists (ACOI) appreciates the opportunity to submit comments in response to the "Bipartisan Medicare Graduate Medical Education (GME) Working Group's Draft Proposal Outline and Questions for Consideration." The ACOI represents the nation's osteopathic internists, medical subspecialists, fellows, residents, and students.

Doctors of Osteopathic Medicine (DOs) are licensed to practice the full scope of medicine in all 50 states and in all specialties. The majority (57 percent) of DOs practice in primary care fields.[1]

The number of osteopathic medical schools has more than doubled over the past two decades, with the majority located in rural or underserved regions. Today there are 41 U.S. colleges of osteopathic medicine at 66 locations in 35 states. About 60 percent of those colleges are located in a federally designated health professional shortage area, and 64 percent require clinical rotations in rural and underserved communities, making them well-situated to help address physician workforce shortages, especially in areas of the country where the need is greatest.

DOs represent a growing segment of the physician community. In 2023, the total number of osteopathic physicians in the United States reached almost 149,000 — a 30 percent increase over the past five years.[2] Today, more than 25 percent of all U.S. medical students are pursuing osteopathic medicine.[3]

[1] Osteopathic Medical Profession Report, 2023. American Osteopathic Association https://osteopathic.org/index.php?aam-media=/wp-content/uploads/2023-OMP-Report.pdf
[2] Ibid.
[3] Ibid.

Despite the growing interest in osteopathic medicine, there is an overall and worsening shortage of physicians across all specialties. The reasons for this are multifactorial ranging from training opportunities, high student debt following medical school, and declining Medicare physician reimbursement. ACOI appreciates your interest in advancing additional Medicare GME proposals to address health care workforce shortages and gaps, and ACOI is pleased to have this opportunity to provide responses to the questions raised in the draft proposal outline.

ACOI is also a member of the Graduate Medical Education Advocacy Coalition (GMEAC) and was a signatory of the Coalition's response to the draft proposal outline. We are pleased to offer additional perspective on some of the questions raised by this Working Group.

ADDITIONAL AND IMPROVED DISTRIBUTION OF MEDICARE GME SLOTS TO RURAL AREAS AND KEY SPECIALTIES IN SHORTAGE

How many additional Medicare GME slots are needed to address the projected shortage of physicians?

ACOI supports the position of the GMEAC that the bipartisan *Resident Physician Shortage Reduction Act* (S. 1302/H.R. 2389), which would provide 14,000 new Medicare-supported GME positions over seven years, represents a strong starting point for further increases.

To address the disproportionate shortage of primary care doctors and psychiatrists, what percentage of new Medicare GME slots should be dedicated toward these two specialties? What additional Medicare GME policies should Congress consider to encourage more residents to enter these specialties?

According to the Association of American Medical Colleges, the projected shortage of primary care physicians is expected to range from 17,800 to 48,000 by 2034, and between 21,000 and 77,100 for non-primary care.[4] The allocation of GME slots should be proportionate to projected needs. However, geographic distribution of those slots should be based on the needs of a particular community.

We suggest there are other steps Congress can take to encourage more residents to enter certain specialties and to practice in rural and medically underserved areas, some of which fall outside the jurisdiction of the Finance Committee, including loan forgiveness programs. For example, ACOI encourages Congress to look at how the Public Service Loan Forgiveness Program (PSLFP), as well as other loan forgiveness programs, can be better leveraged to encourage physicians to practice in rural and underserved areas. For example, PSLFP could be accelerated (70 payments on a direct loan vs. 120) if a physician works in a rural or medically underserved area.

Would the proposed changes to the definition of rural hospitals in the CAA, 2023 GME allocation formula outlined above improve the distribution of slots to rural communities?

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[4] Association of American Medical Colleges, June 2021. https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage

ACOI thanks the Working Group for listening to concerns expressed by stakeholders that there is a need to better target additional GME slots toward rural areas and to improve the retention of physicians in rural and underserved communities.

ACOI supports the *Rural Physician Workforce Preservation Act* (H.R. 8235) which would ensure geographically rural hospitals receive the GME funding prioritization according to Section 126 of the Consolidated Appropriations Act (CAA) of 2021. The CAA created 1,000 new Medicare GME positions to be awarded over five years, designating at least 10 percent of these positions for hospitals serving rural communities. However, many of these designated slots to date have been awarded to rural referral centers located in urban areas, rather than hospitals in rural communities. For example, in last year's allocation, only five of the 200 new residency slots were located in rural areas.

The summary expressed in the Draft Proposal Outline would change the definition of a rural hospital to:

- Exclude hospitals that are treated as being located in a rural area; and
- Include hospitals located in a rural area, hospitals located in an area with a rural-urban commuting code equal to or greater than 4.0, sole community hospitals, and hospitals located within 10 miles of a sole community hospital.

We refer the Working Group to the definition of rural hospital in H.R. 8235, which appears to align with the definition in the Draft Proposal Outline.

How could Congress improve the recruitment of physicians to work in rural or underserved communities? For example, would adding criteria to allocate GME slots for hospitals affiliated with centers of excellence, HBCUs, or MSIs and for hospitals affiliated with non-academic hospital settings improve the distribution of physician training and recruitment in rural and underserved areas?

Teaching Health Centers (THCs) are community-based primary care residency programs that train physicians at community health centers in rural and underserved communities. Currently there are more than 1,000 residents in training at THCs throughout the country, and more than half of THC residents are DOs. Funding for this program expires December 31, 2024. Without a long-term reauthorization, many of these programs may close or otherwise reduce the number of physicians they train, weakening the physician workforce pipeline in their communities. ACOI recommends at least a five-year reauthorization at $300 million per year to provide sustainable funding for existing programs and support the development of new programs.

ACOI also endorses the *Community Training, Education, and Access for Medical Students Act (Community TEAMS Act) (S. 3968)*. While the bill falls under the jurisdiction of the Health, Education, Labor and Pensions Committee, it is important to consider policies that can complement GME legislative proposals. S. 3968 would establish grants through the Health Resources and Services Administration to provide opportunities for colleges of osteopathic and allopathic medicine to secure more clinical rotations and learning opportunities in rural and medically underserved areas, in partnership with federally qualified health centers, rural clinics

and other health care facilities, with the goal of strengthening the physician workforce in these communities.

The practice of medicine in rural and medically underserved areas is unique because resources can be limited, including access to hospitals, testing and specialists, when compared to more urban areas. Medical schools can teach about these barriers, but S. 3968 creates opportunities for medical students to experience them firsthand as they care for and improve the health of patients in these communities.

Doctors of osteopathic medicine have a strong history of serving rural and underserved areas. This legislation will help improve the pipeline of osteopathic medicine physicians who want to practice in these areas. ACOI calls on Congress to pass S. 3968 and to appropriate funding to carry out the bill's objectives.

ENCOURAGING HOSPITALS TO TRAIN PHYSICIANS IN RURAL AREAS

There are a number of factors — demographic, environmental, economic, and social — that can put Americans living in rural areas at higher risk of death than those who live in urban areas. This is especially true for the top five leading causes of death: heart disease, cancer, unintentional injury, chronic lower respiratory disease and stroke. The shortage of health care providers in rural areas exacerbates rural health disparities.[5] To resolve these disparities, health care in rural American needs to be as good, if not better, than health care delivered in other parts of the country.

With approximately one in three adults in America living in rural areas, Medicare has the ability to impact health care in these areas.

Improving the health of people in rural areas requires providing advanced and competent medical care which can be achieved through a medical education and training structure that is adequately funded and supports competencies necessary to practice health care in rural areas.

It is not enough to have a hospital that wants a residency training program. These programs require an infrastructure that supports quality education and the development of faculty who can and want to practice and teach in rural areas. In addition to funding, rural hospitals that want to support residency training must be tied into health care delivery networks, including larger teaching institutions. ACOI believes there is tremendous opportunity for health care delivery innovation in rural areas and is why it is important that health care workforce needs are addressed comprehensively.

What barriers exist for hospitals in rural and underserved areas to launch new residency programs supported by Medicare GME?

The GME funding enterprise is complex and federal funding does not cover all the costs associated with residencies and fellowship. Simply allocating more GME slots to rural areas will not result in more rural hospitals wanting to train physicians.

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[5] https://www.cms.gov/blog/addressing-rural-health-inequities-medicare

We encourage the Working Group to work with stakeholders, including rural hospitals, to better understand why rural hospitals are not applying for GME positions so policies can be tailored to meet their needs along with adequate resources. Federal funding support should also be considered to help hospitals in rural and medically underserved hospitals pay consultants who can evaluate the economic feasibility of the institution to develop the necessary infrastructure for a GME program.

ACOI supports the *Rural Physician Workforce Production Act* (S. 230 / H.R. 834). This bipartisan legislation would increase the physician workforce in rural areas by improving Medicare reimbursement for rural residency training. Physician distribution is influenced by training, and most practice within 100 miles of their residency program. Forty percent of graduating osteopathic medical students plan to practice in an underserved/shortage area; of those, 39 percent in a rural community. Yet, rural hospitals cannot afford to create residency programs because they operate on narrow margins and require a predictable source of funding. S. 230 / H.R 843 helps to solve the geographic maldistribution of physicians and complements other GME initiatives by:

- Lifting the current caps on Medicare reimbursement payments to rural hospitals that cover the cost of taking on residents.
- Allowing critical access hospitals and sole community hospitals to receive an equitable payment for training residents.
- Increasing support for Medicare reimbursement of urban hospitals that send residents to train in rural healthcare facilities.
- Establishing elective per resident payments to ensure rural hospitals have the resources to bring on additional residencies.

What other telehealth flexibilities should the working group consider that would benefit resident physicians who are being trained in teaching hospitals, particularly those located in rural or underserved areas?

In comments to the Centers for Medicare and Medicaid Services last year, ACOI supported the Agency's proposal to allow through December 31, 2024, a teaching physician to have a virtual presence in all teaching settings, but limited to clinical instances when the service is furnished virtually (for example, a three-way telehealth visit, with all parties in separate locations). This flexibility, put in place during the COVID-19 Public Health Emergency, permits teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for all residency training locations. ACOI recommends that this flexibility be made permanent. ACOI suggests that other clinical treatment situations in which it would be appropriate to permit virtual presence of the teaching physician could include regions (e.g., rural and underserved areas) where specialty services and academic services are limited, ambulatory care, critical care, and care for patients in isolation or any environment in which limited direct person-to-person exposure is necessary for the health and safety of the patient.

IMPROVEMENTS TO MEDICARE GME TREATMENT OF HOSPITALS ESTABLISHING NEW MEDICAL RESIDENCY TRAINING PROGRAMS

How much time do hospitals with low GME caps need to reset their caps and should additional hospitals be eligible to reset their low GME caps? What should be the eligibility criteria of these additional hospitals?

Hospitals that have not previously trained residents but triggered the process of setting their resident full-time equivalents (FTE) caps and per resident amounts (PRAs) by allowing residents to rotate to the hospital for the first time have been instrumental in physician training but now cannot sustain their own programs if they become a teaching institution.

ACOI supports resetting the low GME caps of certain hospitals. Specifically, providing 10 years, rather than 5 years, for eligible hospitals to establish a new per resident amount (PRA) or residency full-time equivalent (FTE) cap. ACOI also supports providing a statutory fix for certain hospitals that have had low PRA or FTE caps for a period of 20 cost reporting periods.

The American Association of Colleges of Osteopathic Medicine is working on a proposal, which is supported by ACOI, that would incentivize preceptor participation in the medical education system. Preceptors are physicians who train medical students, usually voluntarily in the community, and play a crucial role in the development of future physicians. Many medical schools report an insufficient number of preceptors caused by changes to the health care delivery system resulting in more clinical demands and reduced reimbursement. Financial support for uncompensated preceptors is needed to increase the supply of physicians to train medical students and deliver quality ambulatory experiences, especially in rural areas and underserved areas.

CONCLUSION

ACOI appreciates your leadership to support and strengthen our country's physician workforce. Thank you for consideration of ACOI's feedback. Requests for additional information or questions should be directed to Tim McNichol, ACOI Deputy Executive Director, at tmcnichol@acoi.org or (301) 231-8877, or Camille Bonta, ACOI consultant, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,

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President, American College of Osteopathic Internists