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

January 30, 2025

The Honorable Bill Cassidy, MD
U.S. Senate
455 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Catherine Cortez Masto
U.S. Senate
520 Hart Senate Office Building
Washington, D.C. 20510

The Honorable John Cornyn
U.S. Senate
517 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Michael Bennett
U.S. Senate
261 Russell Senate Office Building
Washington, D.C. 20510

Dear Sens. Cassidy, Cortez Masto, Cornyn, and Bennett:

The American College of Osteopathic Internists (ACOI) appreciates the opportunity to submit comments in response to your draft legislation that aims to improve the Medicare Graduate Medical Education (GME) program. We appreciate the outreach to stakeholders for input that has occurred throughout the bill drafting process. ACOI was pleased to respond[1] last year to the Bipartisan Medicare GME Working Group's draft proposal outline.

The ACOI represents the nation's osteopathic internists, internal medicine 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 and represent a growing segment of the physician community.

The number of osteopathic medical schools has more than doubled over the past two decades, with the majority of these programs located in rural or underserved regions. There are currently 42 accredited colleges of osteopathic medicine in the United States, delivering instruction at 67 teaching locations in 36 states.[2] At present, these colleges are educating more than 38,000 future physicians—25 percent of all U.S. medical students.[3]

Despite the growing interest in osteopathic medicine, there is an overall and worsening shortage of physicians across all specialties. By 2036, it is projected the physician deficit could grow to up to 86,000.[4] The reasons for this are multifactorial: One reason is that roughly 20 percent of

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[1] American College of Osteopathic Internists response to the "Bipartisan Medicare Graduate Medical Education (GME) Working Group's Draft Proposal Outline and Questions for Consideration." https://www.acoi.org/sites/default/files/uploads/advocacy/ACOI GME Response Letter FINAL 06242024.pdf

[2] American Association of Colleges of Osteopathic Medicine, https://www.aacom.org/become-a-doctor/prepare-for-medical-school/us-colleges-of-osteopathic-medicine#:~:text=There are currently 42 accredited,medicine in the United States.

[3] Ibid.

[4] GlobalData, The Complexities of Physician Supply and Demand: Projections From 2021 to 2036, Association of American Medical Colleges, March 2024. https://www.aamc.org/media/75231/download?attachment#:~:text=Physician demand is projected to,and 86,000 physicians by 2036.

clinical physicians are aged 65 years or older.[5] Other reasons include reimbursement / compensation and burnout,[6] which also must be addressed through Medicare physician payment reform and reduction of regulatory burden. At the same time, by 2040, about 78.3 million people will be 65 or older, more than twice as many as in 2000.[7] We appreciate your addressing gaps in the physician workforce with the urgency it requires.

The 1,200 additional Medicare-funded residency slots provided by the *Consolidated Appropriations Act (CAA)* (2021 and 2023), made an important, yet small, dent in need. ACOI is on record in support of the bipartisan *Resident Physician Shortage Reduction Act* (S. 1302/H.R. 2389) as introduced in the 118th Congress, which would provide 14,000 new Medicare-supported GME positions over seven years. We urge that your legislation stake out a strong starting point for residency position increases based on projected need.

ACOI offers the following comments on the draft legislation:

Section 2. Additional Distribution of Medicare GME Residency Positions to Rural Areas and Key Specialties in Shortage

ACOI supports the draft legislation's requirement that at least 25 percent of new Medicare-funded residency positions should be allocated to primary care over the first five years (2027-2031) of new residency position distribution. Providing more flexibility beginning in 2032 for the Secretary to distribute positions strikes the right balance to ensure workforce needs are being met, including to address the projected shortage of non-primary care physicians.[8] We want to emphasize the shortage of physician specialists in rural and medically underserved areas cannot be solved through increasing residency positions alone. Attracting specialty physicians to these areas will require other investments and policy changes, including loan forgiveness programs and examining how the Public Service Loan Forgiveness Program can be better leveraged.

Consistent with ACOI's past support of the *Rural Physician Workforce Preservation Act* (H.R. 8235) in the 118th Congress, we support that your legislation redefines rural hospitals to remove those hospitals "treated as rural" from the positions designated for rural teaching hospitals. This will ensure residency positions earmarked for rural hospitals are allocated as such.

As presented in your draft legislation, including in the definition of a rural hospital those with a rural-urban commuting code (RUCC) equal to or greater than 4.0 will capture those communities considered "rural" even though they rest within a metropolitan area. We ask you to consider whether your definition of rural hospital should also include those hospitals located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital), or whether using a RUCC equal or greater than 4.0 will generally capture those areas. There may be cases in which States might use broader criteria to classify an area as

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[5] Medford-Davis L, Malani R, et al. The Physician Shortage Isn't Going Anywhere. Sept. 14, 2024, McKinsey & Company. https://www.mckinsey.com/industries/healthcare/our-insights/the-physician-shortage-isnt-going-anywhere

[6] Ibid.

[7] 2023 Profile of Older Americans, May 2024, Administration for Community Living. https://acl.gov/sites/default/files/Profile of OA/ACL_ProfileOlderAmericans2023_508.pdf

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

rural, using factors like land use or access to services and may not otherwise meet the standards presented in your draft legislation.

Among the residency distribution prioritization criteria, the legislation includes those hospitals located in medically underserved areas. While we appreciate the intent of these criteria, the designation of a medically underserved area should be more about the service region (i.e., how many patients are coming to a hospital from rural areas) rather than the location. Furthermore, as also highlighted below, it is difficult for rural and medically underserved areas to attract the minimum number of physicians to oversee and facilitate resident training. Therefore, ACOI recommends that you remove "located in a medically underserved area" at 11(B)(iv)(II) of the draft legislation.

Section 3. Encouraging Hospitals to Train in Rural Areas

ACOI reiterates past comments that to improve the health of people in rural areas, it 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. In this regard, we support expanding the eligibility for indirect medical education payments to sole community hospitals and Medicare-dependent, small rural hospitals that develop or expand an approved medical residency training program. Any investments to support physician training in rural areas also supports and improves the quality of other rural health care education programs, such as those in nursing, therapy, and pharmacy.

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 should be tied into health care delivery networks, including larger teaching institutions that create the ability for resident rotations in specialty areas to occur. While meeting physician workforce needs is a priority, it is also important that medical school graduates receive excellent post-graduate education with high standards, independent of their location.

In comments to the Centers for Medicare and Medicaid Services (CMS) last year, ACOI supported the Agency's proposal to allow through December 31, 2025, a teaching physician to have a virtual presence in all teaching settings. While this extension is limited to clinical instances when the service is furnished virtually, we encourage your legislation to be broadened to allow CMS, in consultation with stakeholders, to allow virtual supervision for select in-person services as well. For example, other clinical situations in which it would be appropriate to permit virtual presence of the teaching physician could include patients in isolation or any environment in which limited direct person-to-person exposure is necessary for the health and safety of the patient.

Section 4. Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage

Before establishing a new Medicare Graduate Medical Education Policy Council, we ask whether it is more practical to leverage the Council on Graduate Medical Education (COGME) for making recommendations to the Secretary on the distribution of residency positions, as well

as for the other functions of the proposed Council. Should you move forward with the establishment of a new Council, we request the composition of the Council be modified so there is at least one *and* equal representation of doctors of medicine and osteopathy.

Section 5. Improvements to Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs

The *CAA*, 2021 gives certain hospitals five years to build their residency programs so they can reset their low GME caps and expand the number of residents they train. In previous comments, ACOI voiced support for resetting the low GME caps of certain hospitals. The five-year cap is too constraining due to challenges with recruitment in rural areas compared to urban areas. We support providing hospitals establishing new medical residency training programs an unlimited amount of time to establish a new per resident amount (PRA) or residency full-time equivalent (FTE) cap.

As an example of why additional or unlimited amounts of time is needed, at one rural East Coast hospital, the clock is ticking on its goal of increasing the number of its residency programs by 2026 — programs that were designed to meet the region's physician workforce challenges, including in geriatrics, neurology, and obstetrics. The hospital has been hampered by the inability to find qualified program directors and faculty. The hospital will lose funding for residency programs not started by July 1, 2026. For this hospital and others like it, an unlimited time to establish a new PRA or residency FTE cap is necessary to meet the needs of rural communities.

We also urge you to consider establishing an incentive structure that would encourage 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, which could be accomplished through tax incentives, for otherwise 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.

Section 6. Improvements to the Distribution of Resident Slots under the Medicare Program After a Hospital Closes

Currently, CMS redistributes residency positions in this order: (1) hospitals in the same core-based statistical area as the closed hospital, (2) hospitals in the same state, (3) hospitals in the same region, and (4) remaining hospitals.

We appreciate the intent behind removing the requirement that hospitals in the same region would need to be considered for the redistribution of residency positions after hospitals in the same core-based statistical area as the closed hospital and hospitals in the same state are first considered. While there may be objections to removing the regional requirement, it would help to ensure that when a hospital in a rural area closes, the residency positions have a greater chance of being redistributed to another rural area. We point out this would not preclude hospitals in the same region as closed hospitals competing for those available residency positions.

Within the prioritization process for redistributing residency positions following a hospital closure, we recommend that some level of prioritization for redistribution be given to similar programs. For example, if the available residency positions stem from an osteopathic program, the positions should be prioritized for another osteopathic program.

Section 7. Improving GME Data Collection and Transparency

We believe the proposed data categories in Section 7 are sufficient for understanding the GME landscape. It is essential the collection and public availability of any resident data be conducted at the hospital level and not the program level to protect residents' privacy.

Conclusion

ACOI appreciates your leadership to support and strengthen our country's physician workforce. Thank you for your 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,

Susan M. Enright, DO, MACOI
President, American College of Osteopathic Internists