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June 23, 2021

VIA ELECTRONIC SUBMISSION

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-172-P
P.O. Box 8013
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

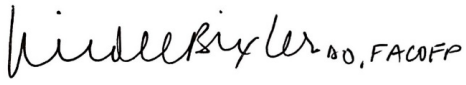
On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Fiscal Year (FY) 2022 Hospital Inpatient Prospective Payment System (IPPS) proposed rule ("Proposed Rule").

ACOFP is the professional organization representing more than 18,000 practicing osteopathic family physicians, residents and students throughout the United States who are deeply committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients have access to high-quality care.

Our comments focus on proposals related to Medicare graduate medical education (GME) and the use of fiscal year (FY) 2019 Medicare hospital data.

Our full comments are detailed on the following pages. Thank you for the opportunity to share our feedback with you. Should you need any additional information or if you have any questions, please feel free to contact ACOFP at advocacy@acofp.org or (847) 952-5100.

Sincerely,



Nicole Bixler, DO, MBA, FACOFP
ACOFP President

ACOFP's comments to the Proposed Rule focus on proposals related to Medicare graduate medical education (GME) slots and the use of Medicare inpatient hospital data. ACOFP generally supports the agency's GME proposals but believes improvements can be made to address the shortage of primary care providers, especially in rural areas. We also urge CMS to use fiscal year (FY) 2020 data to help inform future emergency preparedness policies for providers.

1. **Graduate Medical Education Proposals**

CMS is proposing to implement three provisions of the Consolidated Appropriations Act, 2021 (CAA) that affect Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) payments to teaching hospitals. Specifically, these proposals would distribute additional Medicare-funded residency positions, promote a rural hospital GME funding opportunity for hospitals with rural training track (RTT) programs and provide flexibility for teaching hospitals to establish new medical residency training programs after hosting medical resident rotators for short durations without impacting their full-time equivalent (FTE) resident cap or per resident amount (PRA).

Currently, the United States faces shortages between 21,400 and 55,200 of primary care physicians by 2033.[1] It is critical that the physician training pipeline is immediately strengthened to address the expected workforce shortages in the next few years. ACOFP has long advocated for proposals that would increase the primary care workforce. Therefore, we support CMS's proposal to distribute 200 new Medicare-funded residency positions each year from FY 2023 through FY 2027, as mandated by the CAA, for a total of 1,000 new Medicare-funded residency positions.

We also note that the CAA requires that certain hospitals receive at least ten percent of the residency slots. Those hospitals include:

- Category 1: Hospitals located in rural areas
- Category 2: Hospitals in which the reference resident level for the most recent cost reporting period ending on or before enactment is greater than the resident limit
- Category 3: Hospitals located in states with new medical schools or in states with additional locations established on or after January 1, 2000
- Category 4: Hospitals that serve health professional shortage areas (HPSAs)

While CMS is proposing that hospitals serving HPSAs would qualify under category 4, ACOFP believes this criteria should be improved so that these hospitals specifically should serve primary care geographic HPSAs in order to qualify and should also be required to train primary care residents with the additional residency positions distributed under the CAA. This will help improve access to primary care in areas where it is needed most, and more broadly, help address the serious primary care physician shortage facing the country.

ACOFP appreciates that CMS is implementing section 127 of the CAA, which would provide a cap adjustment for hospitals with RTT programs. Currently, urban hospitals that establish RTTs can receive IME and DGME FTE cap adjustments. However, before the CAA, similar adjustments were not available to rural hospitals participating in RTTs due to Medicare payment rules. The Proposed Rule, pursuant to the CAA, clarifies that each time an urban and a rural hospital establish an RTT for the first time, both the urban and rural hospitals may receive a rural track FTE limitation. Further, the Proposed Rule clarifies that in order for hospitals to receive FTE cap adjustments for residents in RTTs, the residents must be in an accredited program where greater than 50 percent of the program occurs in rural areas. These changes will be effective for cost reporting periods beginning on or after October 1, 2022.

This proposal would allow more residents to gain experience in care delivery in rural settings, which would help prepare young physicians for practicing in rural areas. Practicing in rural areas can be an overwhelming experience for young physicians with some rural communities only having one practicing primary care physician with limited resources. Physicians must be prepared and have the confidence to practice independently to provide the highest quality care possible to the patients in their communities. We believe that this proposal will help prepare young physicians for the unique challenges of practicing in rural areas.

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[1] Stuart Heiser. "New AAMC Report Confirms Growing Physician Shortage." Association of American Medical Colleges. June 26, 2020. Available at https://www.aamc.org/news-insights/press-releases/new-aamc-report-confirms-growing-physician-shortage

Furthermore, the Health Resources and Services Administration (HRSA) has designated 7,200 regions across the country as HPSAs, and nearly 60 percent of those areas are located in rural regions.[2] Evidence suggests that programs exposing residents to rural practice can lead to young professionals practicing in rural areas.[3] It is critical that CMS promotes rural resident training programs to help address the physician shortage in remote areas. Therefore, ACOFP supports the proposed requirement that the RTTs provide at least 50 percent of resident training in rural settings. We believe this ultimately will lead to more young physicians practicing in rural areas.

CMS is also proposing to provide flexibility for certain hospitals that are establishing new medical residency programs. Some hospitals have triggered the establishment of a PRA when they host a small number of residents from a medical school or another hospital. This has created issues for hospitals that would like to establish a new residency program, as the hospital will have a very low PRA and result in low DGME payments. The CMS proposal provides flexibility for hospitals in this unique situation and would allow such hospitals to reset their PRA or adjust FTE amounts.

ACOFP supports these flexibilities, as they will allow more hospitals to establish new resident programs. As mentioned above, the country is facing a physician workforce shortage and it is critical to allow hospitals to establish new residency programs to help address the situation. We also do not believe it is good policy to effectively punish a hospital because it trained a small number of residents on rotation prior to establishing a residency program. Therefore, we support this proposal.

2. Inpatient Hospital Utilization Data

Throughout the Proposed Rule, CMS is proposing to use FY 2019 data for the purpose of establishing inpatient hospital payment rates for FY 2022, as well as assessing performance for Hospital Quality Reporting programs. Under normal circumstances, CMS would use FY 2020 data to calculate FY 2022 rates. However, the agency is concerned that the FY 2020 data is skewed as the result of the COVID-19 public health emergency (PHE). We appreciate that hospitals should not be disadvantaged in payment rate determinations or be held financially accountable for certain performance metrics because of external factors related to the COVID-19 PHE, such as stay-at-home orders and the unique challenges of treating COVID-19 patients.

However, we urge CMS not to completely disregard the FY 2020 data and instead analyze and use them for other important purposes, such as ensuring hospital preparedness throughout the PHE and for future crises. ACOFP believes that reviewing FY 2020 data can help inform future policies. This data could help gauge what types of services have been provided during the pandemic and what hospitals have done to effectively manage patients during the pandemic. This information, therefore, can help CMS identify trends in hospital practices during extreme circumstances, such as the COVID-19 PHE, and identify best practices from effective hospitals.

[2] Kayt Sukel. Dealing with the shortage of rural physicians. Medical Economics Journal. September 10, 2019 edition. Volume 96, issue 17. Accessible here: https://www.medicaleconomics.com/view/dealing-shortage-rural-physicians

[3] Ian MacQueen, Et. Al., Recruiting Rural Healthcare Providers Today: A Systematic Review of Training Program Success and Determinants of Geographic Choices. November 2017. Journal of General Internal Medicine. Accessible here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5789104/