AMERICAN INDIAN
MEDICAL EDUCATION STRATEGIES ALLIANCE

Response to the Medicare GME Working Group's request for feedback on the draft bill:

"To amend title XVIII of the Social Security Area to provide additional and improved distribution of Medicare GME residency positions to rural areas and key specialties in shortage, and for other purposes."

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Introduction:

The American Indian Medical Education Strategies (AIMES) Alliance envisions an environment where urban and rural Tribal members benefit from access to fully staffed medical facilities filled with physicians who provide high-quality and culturally appropriate care and invest in the communities they serve. The AIMES Alliance focuses on expanding graduate medical education at Tribal medical facilities. Our members, including Tribal nations, health organizations, medical schools, health plans, and hospitals, aim to improve healthcare access for American Indian and Alaska Native communities by addressing physician shortages and enhancing training through federal and Tribal partnerships.

General feedback on legislation from members:

1. AIMES Alliance members appreciate the draft legislation and believe that it is a positive step, with the inclusion of Indian Health Service facilities, "Tribally-run" or "638" facilities, and Urban Indian Organizations (I/T/Us) sites to the non-provider list. A dedicated allocation or "carve out" of slots to support I/T/Us would follow the precedent of similar workforce programs at HRSA, and given the nearly 30% physician vacancy rates across IHS facilities and health disparities faced by AI/AN patients, would serve areas in greatest need. This would also serve to uphold the federal trust responsibility.
2. It is critical that all I/T/U sites are made eligible regardless of the Medicare facility classification.
3. There's a concern that GME cost reporting would require separate cost reporting processes for IHS facilities based on Medicare provider definitions. The cost reporting structure of CMS GME funding needs to be realigned to be compatible with payment to IHS facilities (and CAHs and FQHCs). Currently, IHS and CMS have a mutually agreed-upon

agency-level cost-reporting methodology to develop the IHS All Inclusive Rate (AIR), so individual cost reports are not filed: https://www.ihs.gov/businessoffice/reimbursement-rates/.

4. There are costs associated with hosting residents at I/T/Us, such as faculty time and administrative costs. If the training costs incurred fall to I/T/Us alone with no obligation for financial sponsor hospitals to share payments (such as IME) for such costs, there is concern from recent experience with non-provider sites that such arrangements will not be financially sustainable. As it stands, for example, HRSA THCGME programs only cover a portion of the real costs of training. To enable the growth and continuation of these important partnerships, funding should be made available for the additional costs of hosting residents at I/T/Us.
5. AIMES members encourage provision of additional GME funding HRSA programs, Medicaid, and IHS.
    - Under IHS, a new fit-for-purpose GME program, could provide a fixed amount ($300,000) per resident FTE per year, which would include GME and IME expenses in addition to the AIR, for any I/T/U sites participating in an accredited ACGME program directly or through a private partner. This could be handled administratively by IHS without a cost report adjustment and regardless of hospital costs and Medicare provider classification. This would enable greater Tribal sovereignty and self-determination around I/T/U residency programs.
6. Hospitals currently training over their FTE caps would benefit from raising caps or by moving currently unfunded primary care FTEs to some portion of the new slots.
7. Prioritizing family medicine, in addition to primary care, would help fulfill the goals of the working group, as family medicine programs consistently train physicians who remain in primary care, as opposed to pediatrics and IM programs.
8. AIMES members also suggested limiting the applicable psychiatry subspecialties, especially those which are more likely to lead trainees to academic careers rather than positions meeting community needs (ACGME recognizes nine psychiatry subspecialties, of which several were identified as leading to more academic careers e.g., C-L, Sleep, Forensics, and Brain Injury).

Responses to Questions:

1. Is the 30-slot cap appropriate for ensuring fair distribution of residency slots across hospitals? What other strategies could Congress consider to ensure hospitals in all regions have an equal opportunity to compete for slots?

Some AIMES members responded that the 30-slot cap is reasonable, and some would be in favor of raising the cap, although rural programs have typically fewer slots. Members noted a need to support hospitals currently training over the cap without funding. It is critical to ensure programs receive full DGME and IME funding.

2. Is codifying remote supervision the best way to provide flexibility to rural hospitals, or are there alternative approaches Congress should consider?

AIMES members warned that this could be a slippery slope and that for truly rural hospitals, there needs be additional funding rather than just remote supervision. If there could be a cost-plus methodology with some sort of cap, that would be helpful to incentivize rural hospitals. AIMES members also noted that there need be guardrails for how rural hospitals are designated with additional support for truly rural hospitals.

3. Are the proposed data categories in Section 7 sufficient for understanding the GME landscape without overburdening small hospitals? Are there other useful data points or reporting methods that should be included?

AIMES members suggested using the data point of “current practicing locations” for 10 years following graduation.

4. Is creating a GME Policy Council the right approach to guiding future GME slot allocations? Is the scope and responsibility of the Council adequate to make it effective?

AIMES Alliance members recommend that, in line with the federal trust responsibility and efforts to strengthen mechanisms for Tribal representation and input into program development, IHS be given an ex-officio position for representation on the council, as has been previously done with the VA National Academic Advisory Council and the HRSA Council of Graduate

Medical Education. For determining future GME slot allocations, there need be physicians who are familiar with GME that understand the complexities of the program, especially those with experience with GME in Tribal and rural communities. AIMES Alliance members also supported having at least one of the representatives on these committees be a DIO (Designated Institutional Official), who understands the scope of the problem across multiple specialties.

5. Are there any categories of high-need hospitals with potentially higher GME costs that are not already captured in the bonus rates for the proposed standardization of PRA for new slots?

AIMES members suggest I/T/Us, FQHCs, and rural health clinics, given the lack of existing resources for GME support as are available in large academic medical centers.

Sincerely,

The American Indian Medical Education Strategies Alliance