



OFFICERS

Jada Bussey-Jones, MD, FACP
Atlanta, GA
President

Carlos Estrada MD, MS
Birmingham, AL
President-Elect

Martha Gerrity, MD, MPH, PhD, FACP
Portland, OR
Past-President

Arleen F. Brown, MD, PhD, FACP
Los Angeles, CA
Secretary

Elizabeth A. Jacobs, MD, MPP
Scarboro, ME
Treasurer

Susana Rota Morales, MD
New York, NY
Secretary-Elect

COUNCIL MEMBERS

Elizabeth Dzeng, MD, PhD, MPH, MPhil
San Francisco, CA

Marshall Fleurant, MD
Atlanta, GA

Christopher Jackson, MD
Memphis, TN

Danielle Jones, MD, FACP
Atlanta, GA

Wei Wei Lee, MD, MPH
Chicago, IL

Brita Roy, MD, MPH, MHS
New Haven, CT

EX-OFFICIO

Thomas Radomski, MD
Pittsburgh, PA
Chair, Board of Regional Leaders

D. Michael Elnicki, MD
Pittsburgh, PA
Co-Editor
Journal of General Internal Medicine

Michael D. Landry, MD, MSc
New Orleans, LA
Editor, SGIM Forum

Cynthia Chuang, MD, MSc
Hershey, PA
President
Association of Chiefs and Leaders
of General Internal Medicine

Kay Ovington, CAE
Alexandria, VA
Deputy Chief Executive Officer

Eric B. Bass, MD, MPH, FACP
Alexandria, VA
Chief Executive Officer

June 10, 2024

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

SUBMITTED ELECTRONICALLY VIA <http://www.regulations.gov>

Re: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes

Dear Administrator Brooks-LaSure:

The Society of General Internal Medicine (SGIM) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for fiscal year (FY) 2025 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals. SGIM is a member-based medical association of more than 3,300 of the world's leading academic general internal medicine physicians, who are dedicated to delivering high-quality clinical care, improving access for all populations, eliminating health care disparities, and enhancing medical education. Our members are committed to ensuring patients have equitable and affordable access to the highest quality of care possible. Additionally, we recognize the importance of having a well-trained workforce to achieve these goals.

Proposed Changes to the Severity Levels for Z Codes Describing Inadequate Housing and Housing Instability

Building on last year's finalized policy to move certain SDOH diagnosis codes from a non-complication or comorbidity (NonCC) to a complication or comorbidity (CC), in this year's rule, CMS has proposed to move seven inadequate housing (Z59.10, Z59.11, Z59.12, and Z59.19) and housing instability (Z59.811, Z59.812, and Z59.819) ICD-10-CM codes from a NonCC classification to a CC classification. Through this change, CMS will recognize housing instability and inadequate housing as an indicator of increased resource utilization in the acute inpatient hospital setting. SGIM appreciates that CMS continues to promote policy to support and understand the impact of SDOH on healthcare. **As such, we strongly support elevating the severity level of inadequate housing and housing instability ICD-10-CM Z codes from a NonCC classification to a CC classification.**

There are many dimensions of housing instability and inadequate housing, including, but not limited to, having trouble paying rent, poor housing quality, overcrowding, frequent moving, and unstable neighborhoods. Research shows that housing instability and inadequate housing are associated with poor health outcomes and greater health inequities.^{1,2} Housing instability and inadequate housing

¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10203673/>

² <https://nihcm.org/publications/unstable-housing-leads-to-poorer-health-outcomes>



are also associated with higher rates of hospital utilization, including greater admissions and longer lengths of stay, and substantial excess healthcare costs.³

SGIM members provide inpatient care, including at safety-net hospitals, caring for patients who are experiencing housing instability and other unmet health-related social needs. In these settings, reimbursement is low, patient census is high, and documentation burdens are substantial. Therefore, we appreciate that this proposal will allow CMS to capture and appropriately reimburse hospitals for the higher costs and higher resource utilization associated with patients experiencing inadequate housing and housing instability. Moreover, adequate reimbursement should help incentivize utilization of these Z codes which can help drive meaningful evaluation of the association between these Z codes and health outcomes to further refine their appropriate status classifications as CC, NonCC, or major complication or comorbidity (MCC). SGIM believes that any increases in reimbursement for elevating the housing instability and inadequate housing Z codes to CC classification must be sufficiently substantial to meaningfully support overstretched and under-resourced safety net institutions and enhance Z code utilization. Marginal reimbursement increases will not significantly aid progress in these areas or support CMS' health equity mission.

For these reasons, elevating the severity level of these Z codes reflects a crucial step towards ensuring higher quality care for patients facing housing instability and inadequate housing and co-occurring health-related social risk factors. **SGIM urges CMS to finalize this policy and consider the appropriateness of MCC designation for these codes in future rulemaking.**

In a similar manner and consistent with our comments in last year's proposed rule, SGIM strongly encourages CMS to elevate unsheltered homelessness (Z59.02) to an MCC designation. Unsheltered individuals, in particular, face an even higher risk of mortality—three times higher in one study—compared to their sheltered homeless counterparts, and they often die from illnesses such as heart disease, cancer, alcohol use disorder, and liver failure.⁴ While we strongly suggest that CMS consider any form of homelessness as an MCC, we acknowledge that there can be heterogeneity in this experience and its impact on health. An approach currently exists for malnutrition where severity of comorbidity is considered as part of CC vs MCC designation (i.e., mild and moderate malnutrition is a CC while severe malnutrition is an MCC). **As an initial step to this movement, SGIM would strongly encourage consideration of unsheltered homelessness (Z59.02) as an MCC designation.**

Payment for Graduate Medical Education

Proposed Distribution of Additional Residency Positions Under the Provisions of Section 4122 of Subtitle C of the Consolidated Appropriations Act, 2023

SGIM appreciates the work CMS has done in recent years to allocate residency slots for primary care specialties and hospitals serving underserved communities.⁵ However, recognizing that primary care is the foundation of a strong healthcare system, SGIM remains deeply concerned about primary care workforce shortages. There are many areas of the country where patients cannot access general

³<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9664259/#:~:text=These%20findings%20suggest%20that%20coded,and%20substantial%20health%20care%20costs.>

⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6142967/>

⁵ <https://www.cms.gov/newsroom/press-releases/cms-awards-200-new-medicare-funded-residency-slots-hospitals-serving-underserved-communities>



internal medicine physicians who have special expertise in meeting the primary care needs of adults with complex medical conditions, and other health professionals who provide complementary primary care services, such as general pediatricians and family physicians. This is particularly pronounced in rural and underserved communities and safety net hospitals, where disparities and access issues are becoming more pronounced.

SGIM is concerned by recent research showing that half as many medical residents are choosing a career in general internal medicine compared to 10 years ago.⁶ Furthermore, workforce projections from the Health Resources and Services Administration (HRSA) National Center for Health Workforce Analysis project a shortage of 68,020 primary care physicians, including a shortage of 30,080 general internal medicine physicians, by 2036.⁷ Additionally, projections from the Association of American Medical Colleges (AAMC) suggest a shortage of primary care physicians of up to 40,400, a number that the AAMC conveys would be higher if it weren't for recent Congressional investments in Medicare-funded GME.⁸

In this proposed rule, CMS is proposing to distribute 200 new GME slots for FY 2026, as required under section 4122 of the Consolidated Appropriations Act of 2023. SGIM recognizes that, by law, at least half of the positions must go to psychiatry or psychiatry subspecialty residency programs and CMS will reward all qualifying hospitals that submit applications on time to receive an award of up to 1.00 full-time employee (FTE). For remaining slots, CMS will prioritize the distribution based on the health professional shortage area (HPSA) score associated with the program for which each hospital is applying to help bolster the healthcare workforce in rural and underserved areas.

SGIM recognizes that CMS is required to prioritize distribution to psychiatry specialties and subspecialties to improve access to critical mental health services. **However, we urge CMS to ensure that an adequate number of slots go towards primary care and other specialties with well-documented shortages, like internal medicine, family medicine, and pediatrics.** It is important to note that primary care physicians play a significant role in providing mental health care services. A cross-sectional study using Medical Expenditure Panel Survey data found that during the COVID-19 pandemic, primary care physicians provided a significant proportion of care for people with mental health disorders – nearly 40% of visits for depression, anxiety, and any mental illness (AMI) were performed by primary care physicians.⁹ Primary care physicians also provided over one-third of the care and wrote a quarter of the prescribed medications for patients with severe mental illness.

Therefore, we encourage CMS to prioritize distribution of slots going to primary care, and we support the proposal to prioritize the distribution of remaining slots by HPSA score because we believe this will ensure an appropriate number of the new residency positions will go to the hospitals where they will have the greatest impact on access to care—where there are well-documented shortages in primary care and other internal medicine subspecialties. This HPSA-based approach will not only address the current maldistribution of the physician workforce and mitigate workforce shortages in

⁶ Paralkar N, LaVine N, Ryan S, et al. Career Plans of Internal Medicine Residents From 2019 to 2021. *JAMA Intern Med.* 2023;183(10):1166–1167. doi:10.1001/jamainternmed.2023.2873

⁷ <https://tableau.hrsa.gov/t/BHW/views/WorkforceProjections/SupplyDemandTrend>

⁸ <https://www.aamc.org/media/75236/download?attachment>

⁹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8202306/#:~:text=Using%20MEPS%20data%2C%20we%20showed,are%20to%20primary%20care%20physicians>



primary care, including general internal medicine, but also address health inequities and reach underserved populations.

Proposed Modifications to the Criteria for New Residency Programs and Requests for Information

As Congress continues to consider funding new Medicare-funded GME slots, we appreciate CMS' interest in redefining what constitutes a new residency program. Currently, hospitals can receive additional GME cap slots for new residency programs, and we agree with CMS that it is important to ensure that funding is being provided for genuinely new programs. We understand and appreciate CMS' intent to avoid situations where a program at an existing teaching hospital would be transferred to a new teaching hospital, resulting in cap slots created for the same program at two different hospitals.

Newness of residents

In this proposed rule, CMS is proposing that at least 90 percent of trainees must not have previous training in the same specialty for a residency program to be considered new. Typically, when a hospital is creating a new residency program, it recruits recent medical school graduates with no previous residency training experience, otherwise known as first year (PGY1) residents. We understand that there are specific circumstances when a resident might switch from a different specialty to a new internal medicine residency program, and that's acceptable. Additionally, there may also be instances where international medical graduates (IMG) residents may have trained in the same specialty in another country, before training in the U.S., so this 90% threshold would allow for flexibility in those circumstances. However, if more than 10 percent of trainees have transferred from another program in the same specialty, we agree with CMS that the new residency program should not be eligible for new cap slots. **For these reasons, SGIM supports CMS' proposal to institute a 90% threshold for new residents.**

Newness of faculty and program directors

SGIM recognizes that CMS is seeking input on the newness of faculty and program directors. Specifically, CMS seeks input on what proportion of faculty should have no previous experience teaching in the same specialty and CMS is thinking about requiring that half of the teachers must be new, meaning they haven't taught in that specialty program before. **SGIM strongly disagrees with creating this newness criteria which would limit the invaluable expertise that seasoned faculty bring to new residency programs.** There is a greater need for experienced teaching staff in a new residency training program as the development of faculty as skilled teachers are as important as developing the skills of the trainee. The ratio of experienced faculty to new faculty should be greater than half as experienced faculty in a new program will be better skilled to troubleshoot problems appropriately and give guidance to the newer faculty on improving their teaching skills. They can also provide the newer faculty with instruction on various teaching tools to better develop the residents into effective and competent physicians. A new program will face many challenges and will need seasoned and experienced staff who may have encountered similar challenges in the past and can give guidance when developing solutions.

Additionally, CMS is soliciting comments on whether it would make sense to define a period of time (for example, 10 years or 5 years) during which an individual must not have been employed as the program director in a program in the same specialty. **We strongly disagree with this approach as**



this could undermine trainees’ educational experience and create barriers for new residency programs in recruiting faculty and program directors. This is particularly true in rural and underserved areas where physician recruitment and retention are more difficult. It is critically important that MD/DO trainees be trained by MD/DO faculty nearly exclusively in their approach to medicine and primary care. Specialty-congruent expertise is critical for a new program to succeed and thrive, particularly in the earliest stages. If the rationale for this provision is to allow for increased promotional advancement for junior faculty members, SGIM believes that regulating the experience level of a prospective program director is not an effective way of doing this. Additionally, implementing a threshold of this kind would be in direct conflict with the Accreditation Council for Graduate Medical Education’s (ACGME) qualifications for program directors which require program directors to have “specialty expertise and at least three years of documented educational and/or administrative experience.”¹⁰ **For these reasons, SGIM urges CMS not to implement limitations as it relates to the newness of faculty and program directors.**

Number of Residents to Constitute a “Small” Program for Rural Sites

SGIM appreciates that CMS is considering how to define a small residency program as there are unique issues that small and rural residency programs face. Some small programs can have as few as four residents per year, each resident representing 25% of the entire cohort. With small programs like this, program directors often face challenges advocating for residents within existing hierarchies, and the residency program’s reputation is contingent on a small number of residents performing well, passing boards, etc. Additionally, resource constraints and lack of institutional support can be challenging for program directors of small programs, particularly in rural areas. Another issue faced by small programs is that there may not be a critical mass of residents for didactics, morning reports, covering services, etc. Therefore, small programs may need to augment with hospitalists. These combined factors may lead to significant challenges when recruiting program directors to small programs. **Therefore, CMS must take these factors into account when defining small residency programs.**

One Hospital Sponsoring Two Programs in Same Specialty

SGIM appreciates that CMS is looking for feedback on and is investigating what reasons exist for needing two separately approved programs at the same hospital. We believe that there are certain instances where this may be appropriate for the purposes of training. For example, Grady Hospital is a large safety net hospital in the state of Georgia, staffed by two different institutions, Morehouse School of Medicine and Emory University School of Medicine. These private institutions rely on Grady Hospital to train their physicians. Due to the unique nature of these institutions, there are two separate training programs with separate program directors, separate staff, and separately matched residents. Additionally, these programs operate under different rules, priorities, and funding. Furthermore, the University of Pittsburgh Medical Center (UPMC) has two family medicine residency programs housed in different facilities but under the same hospital system - UPMC St. Margaret’s and UPMC Shadyside. As a hospital system, it is reasonable to have two separate staff working in different hospitals and clinics for patient care continuity and ease.

¹⁰ https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2023.pdf



Commingling of New and Existing Residents

CMS is also seeking feedback on the appropriateness of resident “commingling” between new and existing programs. SGIM appreciates CMS’ careful consideration and intent to prevent the creation of new residency slots for a program that looks more like an expansion of an existing program rather than the formation of a genuinely new program. **That said, we believe this practice is appropriate and should be encouraged.** Didactics and educational resources are shared at conferences and through published resources, such as MedED Portal and the Alliance for Academic Internal Medicine’s Primary Care Track Toolkit. Through shared resources, trainees are given a rich and engaging residency experience.

Thank you for the opportunity to provide comments on this proposed rule. SGIM welcomes the opportunity to discuss these issues further. Should you have any questions, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Bussey-Jones', with a stylized flourish at the end.

Jada Bussey-Jones, MD, FACP