Advocating for Family Medicine

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June 16, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1655–P
P.O. Box 8011
Baltimore, MD 21244-1850

Re: Graduate Medical Education provisions within CMS–1655–P

Dear Acting Administrator Slavitt:

On behalf of the Council of Academic Family Medicine (CAFM), including the Society of Teachers of Family Medicine, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, the North American Primary Care Research Group, along with the American Academy of Family Physicians (AAFP), we are pleased to submit comments in response to the proposed rule published in the April 27, 2016 *Federal Register*, titled "Medicare Program; Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System (LTCH PPS) and Proposed Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; and Technical Changes Relating to Costs to Organizations and Medicare Cost Reports."

Our comments focus on the sections of the proposed rule regarding Graduate Medical Education (GME) and originate from our experience, as well as data, indicating that the primary health needs of rural America are not being met. Of particular note, the production of primary care physicians, especially family physicians, is a key area where we believe the Centers for Medicare & Medicaid Services (CMS) can and should do more to remove barriers to increased production. We hope CMS will provide special consideration for underserved rural areas under statutory authority given to CMS for that specific purpose, and will revise this proposal and construct regulations that enhance institutions' ability to produce physicians who will practice in rural areas and serve underserved rural populations.

1. CMS Correctly Proposes to Apply a Five-Year Growth Window to Rural Training Track (RTT) Programs

Changes made in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50111) modified the time-period for growth of residency programs to the establishment of an institution's Full Time Equivalent (FTE) cap from three to five years, to allow sufficient time for its programs to grow to completion. The FTE cap for new residency programs in rural hospitals applies to the cost reporting period that coincides with or follows the start of the sixth program year of each new program started for rural hospitals. The same FTE limitation applies to cap-setting in new urban teaching hospitals.

In this 2017 IPPS/LTCH PPS proposed rule CMS states that when the agency implemented those changes, the regulators inadvertently neglected to change the growth window and effective date of

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FTE limitations for rural training tracks which are still set at 3 years. This proposed rule would apply the same changes to rural training tracks and remove that discrepancy.

We fully support the effort by CMS to extend the time period allowed for growth under the cap-setting limitations of RTT programs. CMS recognizes the concerns that RTTs, like any training programs, need a sufficient amount of time to grow to completion. The purpose is to establish a rural track FTE limitation that reflects the number of FTE residents whom the program will actually train, once it is fully grown. We appreciate the agency's recognition that there are times and circumstances that require amendment of its regulations in the interests of promoting sound public policy when interpreting and implementing the Medicare statute.

2. CMS Should not Apply a Rolling Average During the Cap-Setting Period of RTTs

As part of that extension of time for the cap-setting period for RTTs the proposal states that "due to the statutory language at sections 1886(d)(5)(B) and 1886(h)(4)(H)(iv) of the Act as implemented in our regulations at §§ 412.105(f)(1)(v)(F) and 413.79(d)(7), except for new rural track programs begun by urban teaching hospitals that are establishing an FTE cap for the first time, FTE residents in a RTT at the urban hospital are subject immediately to the 3-year rolling average for direct GME and IME." In other words, unless the hospital is a brand new teaching hospital, the three-year rolling average will continue to apply to resident FTEs training in the rural track program, even during the five-year RTT cap-building window. We are concerned that the impact of the application of the rolling average to new RTTs is extremely detrimental to institutions' ability to establish new RTTs. Instead, CMS should pay for the entire direct and indirect costs of RTT residents, including during the growth window. We believe CMS continues to take an unduly cramped reading of its statutory authority. That authority clearly establishes "special rules" to support training of physicians in rural areas.

For example, Section 1886(h)(4)(H)(iv) of the Social Security Act provides : *Nonrural hospitals operating training programs in rural areas.—In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an rural area or has an accredited training program with an integrated rural track, the Secretary shall adjust the limitation under subparagraph (F) in an* ***appropriate manner*** *[emphasis added] insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas.*

In addition, other statutory language relating to new facilities states the following: *`(i) NEW FACILITIES- The Secretary shall,* ***consistent with the principles*** *[emphasis added] of subparagraphs (F) and (G), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas."*

For the purpose of providing adjustments to the limitations for hospitals establishing residency training programs in rural areas and giving special consideration for new facilities, CMS should not apply the rolling average at the inception of the RTT to help address the nation's need of physicians for these areas. We believe that the special consideration for new facilities should apply because for greater than 50 percent of the time the programs' residents will be situated in a new facility – a new training site – and not in the urban "mother" hospital. Basically the effect of this rule is that urban hospitals will lose one complete years' worth of claims for RTT FTEs. That loss will be spread over 2-4 years, but will be a net loss. The hospital will have to absorb these early losses. Below is a spreadsheet (personal communication, Louis Sanner, MD, May 4, 2016) showing the impact of this loss under various existing scenarios. The dollar amount of these lost resident FTE claims can be

very high and likely to present an insurmountable barrier for many rural communities contemplating starting a Family Medicine training program. Assuming that 1 FTE resident claim on a cost report generates ~$150,000 in Medicare DGME and IME claims the loss with the rolling average rule will amount to $300,000 to $900,000 in the scenarios described below for a 2-2-2 rural training track.

Assumption in examples:

Urban hospital has cap of 30 before starting an RTT and has been claiming 30 each year for many years

1st full year with RTT residents is year 1. the years before RTT starts are year -1 and year -2

hospital is on July-June FY

Scenario A: 2-2-2 RTT that has all of R1 year claimed by 1 urban hospital and all of R2 and R3 years claimed by rural hospital

with **rolling average** the urban hospital would be paid for

FY	core residents	RTT residents	total FTEs	rolling avg FTEs	short vs no rolling avg	
year -2	30	0	30	30	0	
year -1	30	0	30	30	0	
year 1	30	2	32	30.67	-1.33	
year 2	30	2	32	31.33	-0.67	
year 3	30	2	32	32	0.00	
year 4	30	2	32	32	0	
then same	30	2	32	32	0	
					-2	total lost FTE claims

Scenario B: 2-2-2 RTT that has all of R1 year and half of years 2 and 3 claimed by 1 urban hospital and half of R2 and R3 years claimed by rural hospital

with **rolling average** the urban hospital would be paid for

FY	core residents	RTT residents	total FTEs	rolling avg FTEs	short vs no rolling avg	
year -2	30	0	30	30	0	
year -1	30	0	30	30	0	
year 1	30	2	32	30.67	-1.33	
year 2	30	3	33	31.67	-1.33	
year 3	30	4	34	33.00	-1.00	
year 4	30	4	34	33.67	-0.33	
year 5 and after	30	4	34	34.00	0	
					-4	total lost FTE claims

Scenario C: 2-2-2 RTT that has ALL residents claimed by 1 urban hospital. There is no rural hospital

with **rolling average** the urban hospital would be paid for

FY	core residents	RTT residents	total FTEs	rolling avg FTEs	short vs no rolling avg	
year -2	30	0	30	30	0	
year -1	30	0	30	30	0	
year 1	30	2	32	30.67	-1.33	
year 2	30	4	34	32.00	-2.00	
year 3	30	6	36	34.00	-2	
year 4	30	6	36	35.33	-1	
year 5 and after	30	6	36	36.00	0	
					-6	total lost FTE claims

Our comments for items 3 and 4 relate to additional issues affecting rural training track and other rural graduate medical education regulations.

3. Urban Hospitals Must be Allowed to Establish New RTTs at Any Time

The Balanced Budget Act of 1997 established the concept that an urban hospital would be able to increase its cap on residency positions in order to accommodate residents training in rural areas as part of a RTT after the first year of training. The purpose was to allow the residents to obtain enough inpatient training at the urban hospital serving a larger and broader patient population in the first year, and then train in rural, community-based settings for the rest of the residency. RTT residency programs are a proven model for addressing rural physician workforce shortages, with over 70

percent of graduates practicing in rural areas. Most RTTs still do not receive full GME funding for the rural portion of their programs.[1]

Unfortunately, CMS has interpreted the statute to mean that once a cap is set at an urban hospital, for the establishment of a rural training track, no new training tracks at that hospital will be allowed in the same specialty. CMS views the RTT as an expansion of a current residency program, the funding for which is not allowed in statute, rather than as the establishment of a new training program in a new setting for the 2nd and 3rd years. We ask that CMS, using the same statutory authority cited above, allow the establishment of new training tracks by the same urban hospital, in the same specialty, at any time -- and provide for an increase in that urban hospital's cap strictly for the purposes of establishing a new training site whenever a new site is established and in whatever specialty the programs train. The limits on an urban hospital's cap should not be imposed solely on concurrent RTT startups. The establishment of a RTT in a new community should be considered a "new RTT" rather than an expansion of a preexisting RTT, for the purposes of cap-setting in both the urban "mother" hospital and in the rural hospital, no matter when that RTT is established. All FTE residents training in a RTT should be counted and added toward increasing the urban hospital's cap.

4. Artificially Low Caps and Per-Resident Amounts (PRAs) Restrict Medicare GME Funding

Two major limitations in funding rural GME exist based on current rules establishing caps and per-resident amounts. Transient, episodic training of residents in rural hospitals has resulted in artificially low caps on resident training for these hospitals, and artificially low PRAs associated with that hospital. While the rural hospital may expand its cap by establishing a new program, in a different specialty, once the cap is reset, the program cannot expand in the future. Of more concern, the PRA is set forever, even though the hospital has never sponsored a training program, making it unlikely that such a hospital will ever be able to establish a new training program.
While Congress has constrained the growth of Medicare GME spending by limiting the number of residents and costs that a hospital can claim for Medicare GME payments, at the same time it has provided an avenue for non-teaching hospitals, under appropriate circumstances, to establish new teaching programs supported by Medicare GME funding. Unfortunately, however, CMS has imposed limitations on residents and costs in a manner that unfairly penalizes certain hospitals that have, in the past, agreed to allow very small numbers of residents from programs at other hospitals or medical schools to rotate through their facilities for brief periods to enhance those residents' training. Without fair notice, these hospitals have been deemed to be teaching hospitals --- despite neither having been a sponsoring institution, nor claiming IME on their cost reports and permanently saddled with very low resident and cost limits.

We ask that CMS revise its definition of teaching hospital. If a hospital makes no claims for the training of residents in that hospital and is not the institutional sponsor of an accredited, or approved, graduate medical residency program we ask that it not be considered a teaching hospital, and therefore have no cap or PRA established.

We are concerned that CMS, in its rulemaking, has not sufficiently considered its authority to encourage the production of rural physicians. A recent study by Candice Chen, MD, et al, in *Academic Medicine*[2] reports that only 4.8 percent of all graduates of 759 sponsoring institutions practiced in rural areas and 198 of those 759 institutions produced no rural physicians. This

[1] Rural Training Track Technical Assistance Program. http://www.raconline.org/rtt/about_rtts
[2] Candice Chen, MD, et al. Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions. *Academic Medicine*, Vol.88, No. 9. September 2013.

percentage compares extremely unfavorably to the 19.3% of the population classified as rural by the 2010 census[3].

We hope CMS will provide special consideration for underserved rural areas and will construct regulations that enhance institutions' ability to produce physicians who will practice in rural areas and serve underserved rural populations. Should you have any questions regarding this letter, please feel free to contact Hope R. Wittenberg, CAFM Director of Government Relations, at hwittenberg@stfm.org or 202-986-3309, or Robert Bennett, AAFP Federal Regulatory Manager, at rbennett@aafp.org or 202-232-9033.

Sincerely,

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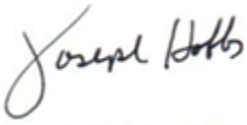

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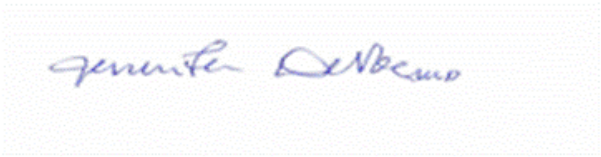

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[3] United States Census Bureau. FAQ: How many people reside in urban or rural areas for the 2010 Census? What percentage of the U.S. population is urban or rural? Available at: https://ask.census.gov/faq.php?id=5000&faqId=5971